

CERTIFICATE OF DEATH

10520

Reg. Dist. No.

10551

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. LENGTH OF STAY IN TB 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 9023 - 49th Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle M Last Angelico				4. DATE OF DEATH Month Sept. Day 22 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1894	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.		IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Pressman				10b. KIND OF BUSINESS OR INDUSTRY Gov't Printing		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Emmanuel Angelico				14. MOTHER'S MAIDEN NAME Mary Maria Pizzimenti			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. None		INFORMANT Address Ruth Angelico, Wife Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Chronic coronary artery disease (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 1 week 4 years 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/14 , 19 59 , to 9/22 , 19 59 , that I last saw the deceased alive on 9/22 , 19 59 , and that death occurred at 11:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE C Louis Mendel				ADDRESS (Street, city or town, state) 4506 COLLEGE AVE DATE SIGNED 9/23/59			
PHYSICIAN'S NAME (Type) Dr. C.L. Mendel				COLLEGE PARK, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Riverdale, Md.				24a. REC'D BY REGISTRAR SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

doi:10.1017/S0022292412001919

• 1992 1000 5000

2004-2005

386 J. M. Smith

10608

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Charles</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf Brandywine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf.</u> <u>08X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brandywine Waldorf Clinic</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WINFORD PRESTON Banks</u>			4. DATE OF DEATH Month Day Year <u>Sept.</u> <u>23</u> <u>1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1910</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>579-87-6649</u>		INFORMANT Address <u>Mr. Ralf. Brown Waldorf, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Diagnosis could not be made</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>yes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>9-9</u> , 19 <u>59</u> , to <u>9-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-23</u> , 19 <u>59</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Brandywine Md</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>	<u>9/25/59</u>	<u>West</u>	<u>Laplata Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Prehart Inc</u> <u>Laplata Md</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10503

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

10503

[Faint, mostly illegible handwritten text follows, likely containing personal and medical details.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10522

10609

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Seat Pleasant			
d. NAME OF HOSPITAL (If not in hospital, give street address) 6901 Avon St.				d. STREET ADDRESS 6901 Avon St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DORA BATEMAN				4. DATE OF DEATH Month Sept. 28th Year 19 59			
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.12.1882	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willis				14. MOTHER'S MAIDEN NAME Mary. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Robert. F. Bateman.		Address 6901. Avon. St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion (b) Hypertensive Coronary (c) Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11.25, 1955, to 9/28, 1959, that I last saw the deceased alive on 9/28, 1959, and that death occurred at 8:57 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William Brainin M.D. 6124 Central Ave 9/28/59 PHYSICIAN'S NAME (Type) WM BRAININ Capitol Hgts Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9.30.59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				24a. REC'D BY REGISTRAR DATE SEP 30 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Knaus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10000

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE DEATH INVESTIGATOR	
NAME OF DECEASED JAMES H. HARRIS		NAME OF DEATH INVESTIGATOR JOHN J. HARRIS	
DATE OF DEATH JAN 10 1900		DATE OF REPORT JAN 10 1900	
PLACE OF DEATH HOME		PLACE OF DEATH HOME	
AGE 40		AGE 40	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
BIRTH DATE JAN 10 1860		BIRTH DATE JAN 10 1860	
BIRTH PLACE BALTIMORE, MD		BIRTH PLACE BALTIMORE, MD	
OCCUPATION CLOCKMAKER		OCCUPATION CLOCKMAKER	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF REGISTRAR JOHN J. HARRIS		SIGNATURE OF DEATH INVESTIGATOR JOHN J. HARRIS	
DATE JAN 10 1900		DATE JAN 10 1900	
PLACE BALTIMORE, MD		PLACE BALTIMORE, MD	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10523

Reg. Dist. No.

10550

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived.; If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b 11 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6703 Cockerville Avenue				d. STREET ADDRESS 6703 Cockerville Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Charles Middle Thomas Last Bern				4. DATE OF DEATH Month September Day 3, Year 19 59											
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-22-1916		9. AGE (In years last birthday) 43 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Service station				10b. KIND OF BUSINESS OR INDUSTRY Service Station				11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Walton Bern				14. MOTHER'S MAIDEN NAME Marie Hess											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-05-5500		17. INFORMANT Marjorie Bern; same address as # 2.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Strangulation</p> <p>974X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) Hanging</p> <p>DUE TO</p> <p>(c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>															
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging. Suicide											
20c. TIME OF INJURY Month, Day, Year Hour 5.00 p. m. 9-3- 59			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Takoma Park		(County) Pr. Geo., Md.						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED							
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9-8-59		22c. NAME OF CEMETERY OR CREMATORY NATL MEM CEM		22d. LOCATION (City, town, or county) (State) FALL CHURCH Va.							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 1400 Chapin St N.W.		24a. REC'D BY REGISTRAR DATE SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John F. Williams		Male		35 years	
Residence		Race		Date of Death	
1234 Baltimore Ave.		White		September 23, 1938	
Occupation		Cause of Death		Place of Death	
Manager		Heart Disease		Home	
Date of Birth		Date of Admission		Date of Discharge	
1903-03-15		1938-09-15		1938-09-20	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date		Time		Place	
1938-09-23		10:00 AM		Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10524

10610

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY VEMANGO ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 8 MOS 17 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRANKLIN		75x-3	
d. STREET ADDRESS 512 McCALMONT STREET			
3. NAME OF DECEASED (Type or print) First CHARLES Middle M Last BLAKE JR		4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1959	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 MAY 18
9. AGE (In years lost birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES M BLAKE SR		14. MOTHER'S MAIDEN NAME DECEASED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES 1941 TO DATE		16. SOCIAL SECURITY NO. 06-09-8827	
17. INFORMANT OFFICIAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 587.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CHRONIC PANCREATITIS (c) CHOLANGITIS		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 18 months 48 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 8 , 19 59 , to SEPTEMBER 25 , 19 59 , that I lost saw the deceased alive on SEPTEMBER 25 , 19 59 , and that death occurred at 6:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James M. Thompson</i>		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED Sept 25, 59	
PHYSICIAN'S NAME (Type or print) JAMES M THOMPSON MAJOR USAF MC		USAF HOSPITAL ANDREWS, ANDREWS AFB, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/59	
22c. NAME OF CEMETERY OR CREMATORY Oil City, Pennsylvania		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rinaldi</i>		24a. REC'D BY REGISTRAR DATE SEP 29 '59	
ADDRESS 816 H St., N.E.		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hana</i>	
Rinaldi Funeral Home, Inc. Washington, D. C.			

CERTIFICATE OF DEATH

10810

MAINTAINING STATE OF DEATH - KANSAS, IN

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Signature of informant: _____

11. Name of informant: _____

12. Address of informant: _____

13. Date of completion: _____

14. Registrar's office: _____

15. County: _____

16. State: _____



CERTIFICATE OF DEATH

Reg. Dist. No.

10525

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale Md.</i> c. LENGTH OF STAY IN b <i>28 hours</i> d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Eugene Leland Memorial Hosp.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince George</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> d. STREET ADDRESS <i>4310 Jefferson ST.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mildred</i> Middle <i>Viola</i> Last <i>Botelean</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>24</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 27 1908</i> 9. AGE (In years last birthday) <i>50</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>South Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry Haliburton</i>		14. MOTHER'S MAIDEN NAME <i>Emma ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>503-18-1130</i>	
17. INFORMANT <i>Hosp. records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i> <i>416X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>auricular fibrillation</i> DUE TO (c) <i>rhumatic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>6 mo</i> <i>undetermined</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>December 1958</i> to <i>Sept 24 1959</i> , that I last saw the deceased alive on <i>Sept 23 1959</i> , and that death occurred at <i>2:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L W Malin</i> M.D. PHYSICIAN'S NAME (Type) <i>L W Malin</i>		ADDRESS (Street, city or town, state) <i>Riverdale, Md.</i> DATE SIGNED <i>9-24-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/26/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 28 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG. FORM 10

PLACE TO BE FILLED BY THE REGISTRAR (To be filled by the Registrar)		PLACE TO BE FILLED BY THE PHYSICIAN (To be filled by the Physician)	
NAME OF DECEASED (Print name in full)		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
DATE OF DEATH (Month, day, year)		TIME OF DEATH (Hour, minute)	
PLACE OF DEATH (Street, city, county, state)		CAUSE OF DEATH (Immediate cause)	
MANNER OF DEATH (Natural, accident, suicide, homicide, undetermined)		MEDICAL HISTORY (Brief description of illness or injury)	
SIGNATURE OF REGISTRAR (Print name and title)		SIGNATURE OF PHYSICIAN (Print name and title)	
OFFICIAL USE (For filing and recording)		REMARKS (Additional information)	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10553

CERTIFICATE OF DEATH

Reg. Dist. No.

10526

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 22½ hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights d. STREET ADDRESS 5406 Gallatin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle E Last Brenner		4. DATE OF DEATH Month Sept Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12 1875
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 3 Days 10 Hours 42 Min.	11. IF UNDER 24 HRS. Months 3 Days 10 Hours 42 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility Man		10b. KIND OF BUSINESS OR INDUSTRY Hechts	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ed Brenner		14. MOTHER'S MAIDEN NAME Mary Virginia Dare	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Alice Brenner, Wife Address Same	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/10 , 19 59 , to 9/13 , 19 59 , that I last saw the deceased alive on Sept 13 , 19 59 , and that death occurred at 3:40P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cheverly Md. DATE SIGNED 9/13/59 ACTUAL SIGNATURE John Kehoe M.D. Cheverly Md. PHYSICIAN'S NAME (Type) Dr. J. Kehoe			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE SEP 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

10553

10553

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		10-15-1965	
Age		35 years	
Sex		Male	
Race		White	
Marital Status		Married	
Place of Birth		New York, N.Y.	
Usual Residence		123 Main St., New York, N.Y.	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Atherosclerosis	
Manner of Death		Natural	
Physician's Signature		[Signature]	
Physician's Name		Dr. J. K. Smith	
Physician's Address		456 Elm St., New York, N.Y.	
Physician's Phone		[Phone Number]	
Date of Signature		10-16-1965	
Registrar's Signature		[Signature]	
Registrar's Name		John Doe	
Registrar's Address		789 Broadway, New York, N.Y.	
Registrar's Phone		[Phone Number]	
Date of Registration		10-16-1965	

CERTIFICATE OF DEATH

Reg. Dist. No.

10527

10554

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly c. LENGTH OF STAY IN 1b 10 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier d. STREET ADDRESS 4014 37th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle A. Last Brown		4. DATE OF DEATH Month Sept Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Payne		14. MOTHER'S MAIDEN NAME Mary Virginia Claggett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Robert Brown, Husband, Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-6 , 19 59 , to 9-17 , 19 59 , that I last saw the deceased alive on 9-16 , 19 59 , and that death occurred at 3:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Waldo B. Moyer M.D. 3503 Perry St 9-17-59 PHYSICIAN'S NAME (Type) Dr. Waldo B. Moyer Mt. Rainier Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE SEP 21 '59	24b. REGISTRAR'S SIGNATURE Chas. & K. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

1924

IN SENATE,
January 14, 1924.
REPORT OF THE
COMMISSIONERS OF THE
LAND OFFICE,
FOR THE YEAR
1923.
ALBANY:
JANUARY 14, 1924.



ALBANY:
JANUARY 14, 1924.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10528

10611

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>P. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>6 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6643 TEMPLE HILLS RD.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BESSIE LEE BROWN</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 24 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 4-1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BRUCE BELL</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES DOWNS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SON-JOHN R. BROWN</u>		Address <u>6641 TEMPLE HILLS RD. CLINTON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>MULTIPLE MINOR CEREBRAL VASCULAR</u> DUE TO <u>ACCIDENTS</u> (c) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DIS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>NONE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> <u>2 1/2 RS.</u> <u>10 DRS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> 19 <u>59</u> P. M. <u>None</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) (County) (State) <u>None</u> <u>None</u> <u>None</u>
21. I certify that I attended the deceased from <u>SEPT. 16, 1959</u> to <u>Present</u> that I last saw the deceased alive on <u>SEPT. 16, 1959</u> , and that death occurred at <u>1:40</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Branch Ave. Clinton, Md.</u> DATE SIGNED <u>9/24/59</u>			
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. BRANCH AVE. CLINTON MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>P. Geo. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Inc.</u> ADDRESS <u>517-11th St. SE Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur Shaver</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1961

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. DATE OF BIRTH 12/5/25		6. PLACE OF BIRTH Jackson, Mississippi	
7. MARITAL STATUS Single		8. OCCUPATION Minister		9. CAUSE OF DEATH Suicide	
10. MANNER OF DEATH Natural		11. PLACE OF DEATH Baltimore, Maryland		12. DATE OF DEATH 4/4/68	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF WITNESS JAMES EARL RAY		15. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
16. SIGNATURE OF CORONER JAMES EARL RAY		17. SIGNATURE OF JURY JAMES EARL RAY		18. SIGNATURE OF JUDGE JAMES EARL RAY	
19. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		20. SIGNATURE OF CLERK JAMES EARL RAY		21. SIGNATURE OF REGISTRAR JAMES EARL RAY	
22. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY		23. SIGNATURE OF SHERIFF JAMES EARL RAY		24. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY	
25. SIGNATURE OF COUNTY CLERK JAMES EARL RAY		26. SIGNATURE OF STATE CLERK JAMES EARL RAY		27. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
28. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		29. SIGNATURE OF UNITED NATIONS CLERK JAMES EARL RAY		30. SIGNATURE OF WORLD CLERK JAMES EARL RAY	

1

1. NAME OF DECEASED
JAMES EARL RAY

2. SEX
Male

3. AGE
35

4. RACE
White

5. DATE OF BIRTH
12/5/25

6. PLACE OF BIRTH
Jackson, Mississippi

7. MARITAL STATUS
Single

8. OCCUPATION
Minister

9. CAUSE OF DEATH
Suicide

10. MANNER OF DEATH
Natural

11. PLACE OF DEATH
Baltimore, Maryland

12. DATE OF DEATH
4/4/68

13. SIGNATURE OF DECEASED
(None)

14. SIGNATURE OF WITNESS
JAMES EARL RAY

15. SIGNATURE OF PHYSICIAN
JAMES EARL RAY

16. SIGNATURE OF CORONER
JAMES EARL RAY

17. SIGNATURE OF JURY
JAMES EARL RAY

18. SIGNATURE OF JUDGE
JAMES EARL RAY

19. SIGNATURE OF DISTRICT ATTORNEY
JAMES EARL RAY

20. SIGNATURE OF CLERK
JAMES EARL RAY

21. SIGNATURE OF REGISTRAR
JAMES EARL RAY

22. SIGNATURE OF CHIEF OF POLICE
JAMES EARL RAY

23. SIGNATURE OF SHERIFF
JAMES EARL RAY

24. SIGNATURE OF TOWNSHIP CLERK
JAMES EARL RAY

25. SIGNATURE OF COUNTY CLERK
JAMES EARL RAY

26. SIGNATURE OF STATE CLERK
JAMES EARL RAY

27. SIGNATURE OF NATIONAL CLERK
JAMES EARL RAY

28. SIGNATURE OF INTERNATIONAL CLERK
JAMES EARL RAY

29. SIGNATURE OF UNITED NATIONS CLERK
JAMES EARL RAY

30. SIGNATURE OF WORLD CLERK
JAMES EARL RAY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 6 Film G248 9-18-59 et
 10612
 CERTIFICATE OF DEATH

10529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X University Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4221 Sheridan St.				d. STREET ADDRESS 4221 Sheridan St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Richard Middle Franklin Last Bullock				4. DATE OF DEATH Month September Day 10 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1904	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teller, Foreign Ex.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard Edmund Bullock				14. MOTHER'S MAIDEN NAME Emma Mae Mervine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT D.R. Purdie, M.D.			Address Riverdale, Md. 4404 Queensbury Rd.,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver, metastatic, primary site colon 153.8 DUE TO Primary site colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary site colon DUE TO (c) Primary site colon						INTERVAL BETWEEN ONSET AND DEATH approx. 9 mo 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 7-4 , 19 59 , to 9-10 , 19 59 , that I last saw the deceased alive on 9-10 , 19 59 , and that death occurred at 10:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE D.R. Purdie		ADDRESS (Street, city or town, state) 4404 Queensbury Rd.		DATE SIGNED 9-10-59			
PHYSICIAN'S NAME (Type) D.R. Purdie, M.D.,		Riverdale, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sep 14, 1959	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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10613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 1 Box 263</u>		d. STREET ADDRESS <u>RT 1 Box 263</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES JEROME BURCH</u>		4. DATE OF DEATH <u>SEPT. 12 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES BURCH</u>		14. MOTHER'S MAIDEN NAME <u>MARY THOMPSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-05-6293</u>	
17. INFORMANT <u>WIFE - Florence Burch</u>		Address <u>RT 1 Box 263 Clinton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INANITION</u> DUE TO <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CARCINOMA with</u> DUE TO <u>generalized metastases</u> (c) <u>9 mos.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> 19	20d. INJURY OCCURRED While <u>None</u> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>58</u> , to <u>Present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT. 12, 1959</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D. <u>Branch Ave. - Clinton, Md.</u>		DATE SIGNED <u>9/12/59</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elder Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sinclair Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u> ADDRESS <u>1661-9d Hope Rd SE</u>		24. REC'D BY REGISTRAR <u>DATE SEP 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10531

10555

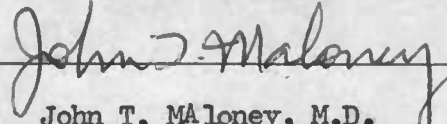
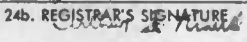
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LeLand Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Lois Last Burt				4. DATE OF DEATH Month September Day 27 Year 19 59			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-25 / 9	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months 40 Days 40	IF UNDER 24 HRS. Hours 40 Min. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Murray				14. MOTHER'S MAIDEN NAME Della Semonis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 229-24-5647		17. INFORMANT Ralph Murray; Box 244, Laurel, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushed chest DUE TO (c) Automobile accident							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with another auto.					
20c. TIME OF INJURY Hour 2.00 p.m. 9-27-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Near Laurel, Howard	(County) Maryland	(State) Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/59		22c. NAME OF CEMETERY OR CREMATORY Madamidge Memorial Park		22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson, Laurel, Md				24a. REC'D BY REGISTRAR DATE OCT 1 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10532**

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Forest			c. LENGTH OF STAY IN 1b 2½ mon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Forest		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8019 Barlowe Road				d. STREET ADDRESS 8019 Barlowe Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle Neale Last Byrd				4. DATE OF DEATH Month September Day 23 Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-23		9. AGE (In years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Machinery		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Byrd				14. MOTHER'S MAIDEN NAME Addie Timmions			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2 577-18-3511		17. INFORMANT Doris Jean Byrd; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of chest (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound.					
20c. TIME OF INJURY Month, Day, Year 11.45 a.m. 9-23-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Kent Forest Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER KK			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-25-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.				22d. LOCATION (City, town, or county) (State) Suitland, Md.		24a. REC'D BY REGISTRAR SEP 25 1959	
				24b. REGISTRAR'S SIGNATURE 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

10556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 904 64th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Any Middle Carroll Last Sept.				4. DATE OF DEATH Month Sept. Day 25 Year 19 59			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Johnson				14. MOTHER'S MAIDEN NAME Serena Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Maggie Iverson 1226 G Street, N.E. Wash, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 21, 1959 to Sept 26, 1959 , that I last saw the deceased alive on Sept 25, 1959 and that death occurred at 2:45 AM , from the causes and on the date stated above. Stuart Wodak ADDRESS (Street, city or town, state) 30 Ridge Rd., Greenbelt, Maryland DATE SIGNED							
ACTUAL SIGNATURE Dr. Hans Wodak M.D. 30 Ridge Rd., Greenbelt, Maryland							
PHYSICIAN'S NAME (Type) Dr. Hans Wodak							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59		22c. NAME OF CEMETERY OR CREMATORY Carroll Chapel		22d. LOCATION (City, town, or county) (State) Mitchellville Prince Georges Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR SEP 30 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneel			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10534

10557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 H attsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5504 43rd Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn Elizabeth Clarke				4. DATE OF DEATH Month 9-16-59 Day 19 Year 19		5. SEX Female	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-30-83		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ????????? Parsons				14. MOTHER'S MAIDEN NAME Laura Perkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-40-5459		17. INFORMANT Address Jessie M Weaver; 45 Tudor City Place, N.Y. City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 17, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/18/59		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE SEP 21 '59	
24b. REGISTRAR'S SIGNATURE Robert E. K...							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10535

10558

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 6651 Temple Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DALE First DEAN Middle COFFMAN Last				4. DATE OF DEATH Sept. Month 9 Day 19 Year 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1936		9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Sand & Gravel		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor Coffman				14. MOTHER'S MAIDEN NAME Marian Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Edna L. Southard		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 914.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Electrocuted while using a steam pressure cleaner on a loader					
20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 9-9- 19 59		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) sand and gravel pit, Silver Hill Pr. Geo. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 9, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				ADDRESS 1661 - Good Hope Rd SE Wash DC		24a. REC'D BY REGISTRAR DATE SEP 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED'S NAME

AGE

SEX

RACE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

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• *Journal of the American Medical Association*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10559

CERTIFICATE OF DEATH

10537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL adm. 10-14-1940 Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 VOI-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		d. STREET ADDRESS 2125 N. CALVERT STR.	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA AUGUSTA COLLIER		4. DATE OF DEATH Month Day Year Sept 5 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept -25-1864
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.-A.	
13. FATHER'S NAME SIMON BRADY		14. MOTHER'S MAIDEN NAME —? STEELE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT HOSPITAL RECORDS LAUREL SANITARIUM		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO AURICULAR FIBRILLATION 433.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL DEGENERATION 422 DUE TO MANY YEARS (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arterio sclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Interval between onset and death SEVERAL WEEKS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept -5- 19 59 to Sept -5- 19 59 , that I last saw the deceased alive on Sept -5- 19 59 , and that death occurred at 9 10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edna P. Kraemer M.D.		ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 9-5-59	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8/59	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.		22d. LOCATION (City, town or county) (State) Dorsey, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraemer	

4 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
10560 11694											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 5027 37th Avenue						
3. NAME OF DECEASED (Type or print) First Middle Last					4. DATE OF DEATH Month Day Year						
5. SEX Female					6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-14-1900		
9. AGE (In years last birthday) 59 yrs.					10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Robertson					14. MOTHER'S MAIDEN NAME Jessie M. Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address James E. Conaway; same address as #2.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock											
DUE TO (b) Spontaneous intracranial hemorrhage and											
DUE TO (c) Hemorrhage due to fall in the home.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in the home						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9-3- 19 59					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hyattsville, Pr. Geo. (County) Md. (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John T. Maloney					M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 6, 1959		
EXAMINER'S NAME (Type) John T. Maloney, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation			22b. DATE THEREOF 9-9-59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematorium			22d. LOCATION (City, town, or country) (State) Prince George, Maryland			
23. FUNERAL DIRECTOR Deal Funeral Home 4812 Gr. Ave.					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Evans				

MEDICAL CERTIFICATION

11604

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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THE STATE
OF NEW YORK

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10561

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville 15				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 3325 Lancer Drive															
3. NAME OF DECEASED (Type or print) First Ruth Middle Eveline Last Coveney				4. DATE OF DEATH Month Sept Day 21 Year 19 59															
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept., 14, 1900		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS. Days 1 Hours 15 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Nursing				11. BIRTHPLACE (State or foreign country) Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Dennis J. Coveney				14. MOTHER'S MAIDEN NAME Rose E. Bevans															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No				INFORMANT Helena Coveney, Sister,				Address Same as # 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Uremia DUE TO (c) Nephrosclerosis												INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-15 , 19 59 , to 9-21 , 19 59 , that I last saw the deceased alive on 9-21 , 19 59 , and that death occurred at 11:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Petty St Baltimore Md DATE SIGNED 9-22-59																			
ACTUAL SIGNATURE Waldo B. Moyers				M.D. 3503 Petty St															
PHYSICIAN'S NAME (Type) Waldo B. Moyers																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/25/59				22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland				24a. REC'D BY REGISTRAR DATE SEP 28 59				24b. REGISTRAR'S SIGNATURE Arthur A. Harris							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

State of Maryland, County of Baltimore, City of Baltimore

On the 14th day of January, 1938

at the residence of the deceased, 1234 North Avenue

John Doe, aged 65 years, died of

Heart Disease

His last illness was of short duration

and he died peacefully

in the arms of his family

His funeral services were held on

the 16th day of January, 1938

at the Central Baptist Church

and were conducted by the Rev.

John Doe, Minister of the Gospel

of the Central Baptist Church

and he was buried in the

Central Baptist Church

and the remains were

deposited in the

Central Baptist Church

and the remains were

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10615

CERTIFICATE OF DEATH

Reg. Dist. No.

10539

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANN Middle MARGUERITE Last CRABTREE		4. DATE OF DEATH Month SEPTEMBER Day 10 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 31, 1959
9. AGE (In years last birthday) NA yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARVIN D CRABTREE		14. MOTHER'S MAIDEN NAME SHIRLEY A LOWE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT SEE SECTION 13		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, PROBABLY STAPHYLOCOCCAL 692.6 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) STAPHYLOCOCCAL ABSCESS, LEFT KNEE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PREMATURITY		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 AUG , 1959, to 10 SEP , 1959, that I last saw the deceased alive on 10 SEP , 1959, and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF HOSP ANDREWS, ANDREWS AFB DATE SIGNED 10 SEP 59			
ACTUAL SIGNATURE John A Moore		M.D. USAF HOSP ANDREWS, ANDREWS AFB	
PHYSICIAN'S NAME (Type) JOHN A MOORE CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Linardi Funeral Home, Inc.		ADDRESS 816 N St NE, DC	
24a. REC'D BY REGISTRAR SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	

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(A)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10540

10562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 N. Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3907 Wallace Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Belle Last Culley				4. DATE OF DEATH Month September Day 13 Year 19 59			
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-27-18		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY U. of Md.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Powell				14. MOTHER'S MAIDEN NAME Ida Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-2201		17. INFORMANT Samuel Culley; 1507 52nd Ave, Beaver Hts., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 421.4 DUE TO Chronic Valvular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-18-59		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS Co. 1432 10th ST. N.W.				24a. REC'D BY REGISTRAR SEP 16 59		24b. REGISTRAR'S SIGNATURE Arthur G. Kenna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John T. [illegible]		Date of Death 1-27-10	
Place of Birth [illegible]		Age 30	
Sex Male		Race White	
Occupation [illegible]		Cause of Death [illegible]	
Medical History [illegible]		Post-mortem Examination [illegible]	
Signature of Medical Examiner [illegible]		Signature of Coroner [illegible]	

CERTIFICATE OF DEATH

Reg. Dist. No.

10563

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Giles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) Leila Dunn Cummings				4. DATE OF DEATH Sept. 11 19 59			
5. SEX Female	6. COLOR OR RACE White	7. NAME OF DECEASED WIDOWED	8. DATE OF BIRTH Mar. 28, 1872	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT William Barker, 5511--38th Ave. Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction, acute anterior DUE TO (b) Coronary Thrombosis, acute DUE TO (c) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus mild							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 7 , 19 59 , to Sept. 11 , 19 59 , that I last saw the deceased alive on Sept. 10 , 19 59 , and that death occurred at 12:10AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rossen, M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Rd. Bladensburg Md.		DATE SIGNED 9/11/59			
PHYSICIAN'S NAME (Type) Dr. William D. Rossen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/1959		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Narrows, Giles Co., Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1963

DATE OF DEATH

DATE

PLACE

NAME OF HOSPITAL

CAUSE

AGE

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

PREVIOUS ILLNESS

DIAGNOSIS

DATE

DATE OF DEATH

TIME

PLACE

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10542

Reg. Dist. No.

10615

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale			c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4906 Russell Avenue				d. STREET ADDRESS 4906 Russell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) James Emmett Davis				4. DATE OF DEATH Month September Day 29 Year 19 59				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-92		
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66		IF UNDER 24 HRS. Hours 66 Min. 66				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rodman, retired			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Owen Davis				14. MOTHER'S MAIDEN NAME Mary Ellen Tyson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-3391		17. INFORMANT Shirley D. Robertson; 6303 46th Avenue, Riverdale, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)</p> </div> <div style="width: 35%; border: 1px solid black; padding: 5px;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home				24a. REC'D BY REGISTRAR DATE OCT 2 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hume		
22d. LOCATION (City, town, or county) (State) Smithland Md								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10012

Name of Deceased		Place of Birth		Date of Birth	
John Doe		New York		1900	
Sex		Race		Religion	
Male		White		Catholic	
Marital Status		Occupation		Education	
Married		Teacher		High School	
Date of Death		Cause of Death		Manner of Death	
1950-12-25		Heart Failure		Natural	
Place of Death		Physician		Hospital	
Home		Dr. Smith		St. Mary's	
Signature of Examiner		Signature of Coroner		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		City		County	
1951, 01, 01		New York		New York	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10543

Reg. Dist. No.

10564

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Crimora Last Davis		4. DATE OF DEATH Month Sept. Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 31, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Swartzel		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John H Davis		Address Grottoes Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-1959	
22c. NAME OF CEMETERY OR CREMATORY Thomassess		22d. LOCATION (City, town, or county) (State) Stanton Va	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		ADDRESS 131-11 24 Wash D.C.	
24a. REC'D BY REGISTRAR DATE SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneas	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1963	
Place of Birth		Date of Birth		Cause of Death		Manner of Death	
New York City		1918		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses	
Teacher		High School		Married		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Remarks	
1963		10:00 AM		City Hall		[Remarks]	

10565

CERTIFICATE OF DEATH

10544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Elliott Last Dennis		4. DATE OF DEATH Month Sept. Day 28 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 June 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 10 Days 4 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Triangle Construction Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Henry Dennis		14. MOTHER'S MAIDEN NAME Susan Elizabeth Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 225-07-3246	
17. INFORMANT Corrine Dennis, Wife		Address Same #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Pulmonary Cong. redmen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Arterio sclerosis Ht dis DUE TO (b) 3 years DUE TO (c) 10 days		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to Sept 28 , 1959, that I lost saw the deceased alive on Sept 27 , 1959, and that death occurred at 6:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. R. Levitsky		ADDRESS (Street, city or town, state) 3408 Rhode Is Ave DATE SIGNED 9/28/59	
PHYSICIAN'S NAME (Type) Dr. L.R. Levitsky., M.D.		MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/2/59	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St. N.W.		24a. REC'D BY REGISTRAR SEP 30 '59	
ADDRESS Washington, D.C.		24b. REGISTRAR'S SIGNATURE Arthur E. Frank	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

DECEASED

NAME

AGE

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

DATE

TIME

PLACE

NAME

DATE

TIME

PLACE

NAME

DATE

TIME

PLACE

NAME

DATE

TIME

PLACE

NAME

DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10545

Reg. Dist. No.

10566

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS Jimmie's Fruit Stand Rt. 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Patrick Middle Wallace Last Diggs				4. DATE OF DEATH Month September Day 20 Year 19 59					
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1887		9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker			10b. KIND OF BUSINESS OR INDUSTRY Fruit stand		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Patrick Diggs				14. MOTHER'S MAIDEN NAME Louise West					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Louise Morris; 851 20th St., Washington, D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 916.6 Conditions, if any, which gave rise to immediate cause (b) Universal 2nd and 3rd degree burns of body (c) 916.6 DUE TO Universal 2nd and 3rd degree burns of body PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in fruit stand.	
20c. TIME OF INJURY Month, Day, Year 4.00 a.m. 9-19-59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fruit stand		20f. (City or town) (County) (State) Upper Marlboro Pr. Geo. Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.									
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED September 20, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-23-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fragers Funeral Home</i>				24a. REC'D BY REGISTRAR DATE SEP 22 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10617

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 3 HRS 15 MIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DRIFKE Middle N/B Last FEARLE		4. DATE OF DEATH Month SEPTEMBER Day 9 Year 1959	
5. SEX FE MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 SEP 59
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK DRIFKE		14. MOTHER'S MAIDEN NAME SHIRLEY A WASHTAK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NA	
17. INFORMANT SEE SECTION 13		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 HRS 15 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 SEP , 19 59 , to 9 SEP , 19 59 , that I last saw the deceased alive on 9 SEP , 19 59 , and that death occurred at 1:28A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sanford L Billet</i>		ADDRESS (Street, city or town, state) USAF HOSP ANDREWS, ANDREWS AFB DATE SIGNED 9 SEP 59	
PHYSICIAN'S NAME (Type) SANFORD L BILLET		CAPT USAF MC USAF HOSP ANDREWS AFB WASHINGTON 25 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-9-59	
22c. NAME OF CEMETERY OR CREMATORY D. C. Morgue		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE -----		ADDRESS	
24a. REC'D BY REGISTRAR DATE SEP 11 '59		24b. REGISTRAR'S SIGNATURE <i>Christina & Hines</i>	

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

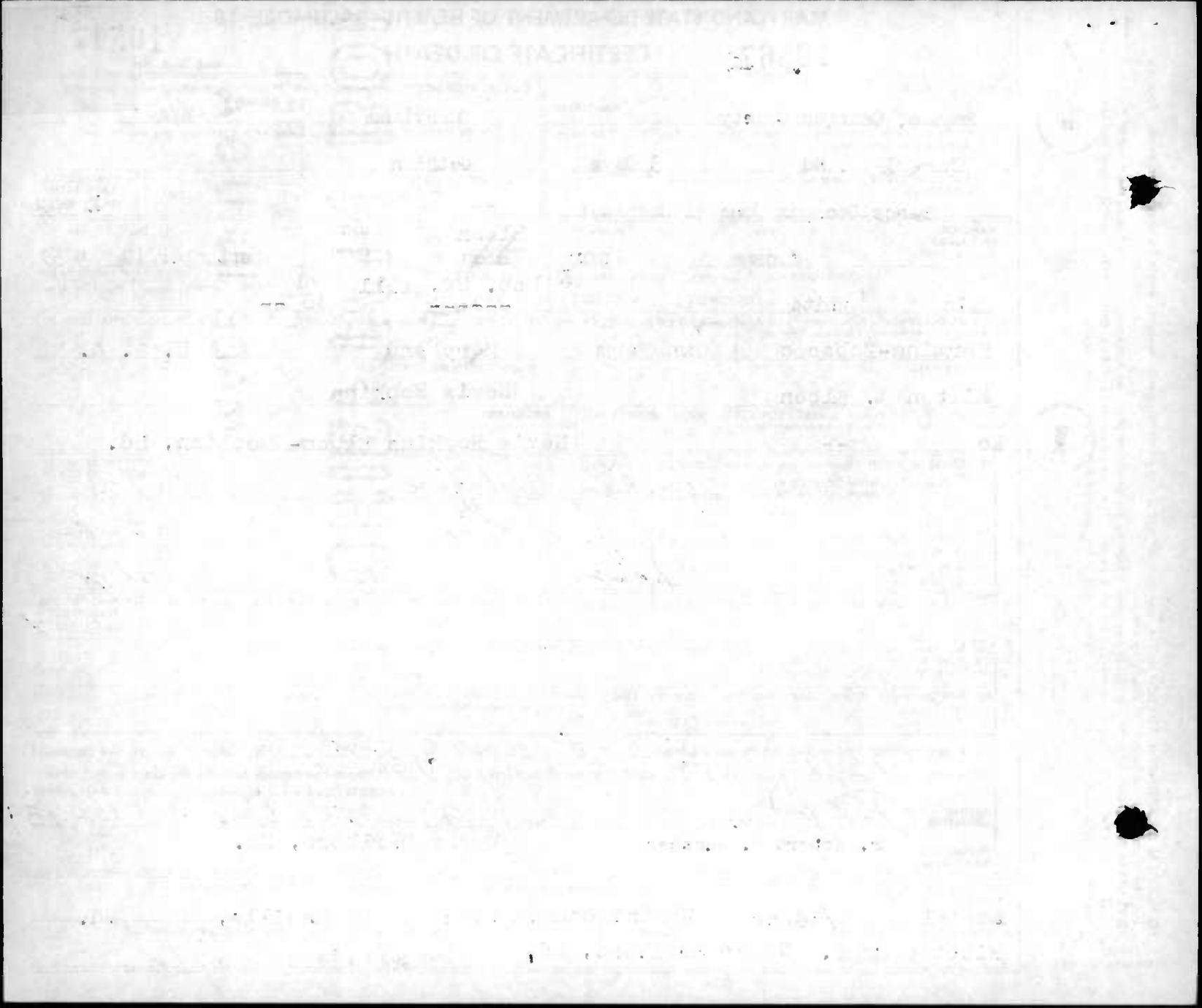
10567

CERTIFICATE OF DEATH

10547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince, Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A/A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u> <u>02X-2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>--</u>			
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>John</u> Last <u>Elben</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1911</u> <u>2/24/11</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>48</u> Days <u>19</u> Hours <u>59</u> Min.	IF UNDER 24 HRS. Months <u>48</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming-Tobacco</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Milton S. Elben</u>				14. MOTHER'S MAIDEN NAME <u>Nevia Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>		INFORMANT Address <u>Nevia Hopkins Elben- Lothian, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>581.1</u> IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> DUE TO (b) <u>Cirrhosis of Liver</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (c) <u>Alcoholism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 wks.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 Sept</u> , 19 <u>59</u> , to <u>10 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 Sept</u> , 19 <u>59</u> , and that death occurred at <u>7/45P</u> , M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Robert B. Sasscer</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Upper Marlboro Md 10 Sept 1959</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Robert B. Sasscer</u>				M.D. <u>Upper Marlboro, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kenna</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newton Village Md		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4916 Monroe Street,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Fierstein Last Fierstein		4. DATE OF DEATH Month Sept. Day 20, Year 19 59-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Roth		14. MOTHER'S MAIDEN NAME Johanna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Carl A. Fierstein		Address Newton Village, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 hr.			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-20-59 to 9-20-59 , that I last saw the deceased alive on 9-20-59 , and that death occurred at 9-20-59 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Hays M.D.		DATE SIGNED Hyattsville, Md. 9/22/59	
PHYSICIAN'S NAME (Type) Leonard Hays		Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/23/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CENTRAL STATE OF DEATH

10613

1

10619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Agasco</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dobson Clinic</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rosalie Eugenia Hall Forbes</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>5</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Snowden Hall</u>		14. MOTHER'S MAIDEN NAME <u>Stella Gill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>George F. Forbes Jr.</u>		Address <u>Bryantown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unfulfilled cardiac-vascular. Reel Decease</u> DUE TO (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-5</u> , 19 <u>59</u> , to <u>9-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-7</u> , 19 <u>59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.		ADDRESS (Street, city or town, state) <u>Bryantown Md</u> DATE SIGNED <u>9-7-59</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>		<u>Bryantown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Dominics</u>	22d. LOCATION (City, town, or county) (State) <u>Agasco, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Thrift Funeral Home, Waldorf, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>SEP 11 '59</u>		<u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

10010

DEPARTMENT OF HEALTH - BALTIMORE

10010

Age

Sex

Color

Height

Weight

Place of Birth

Country

State

City

Occupation

Education

Marital Status

Religion

Usual Residence

Address

City

State

Date of Death

Time of Death

Place of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Family Physician

Signature of Hospital Physician

Signature of Nursing Home Physician

Signature of Other Physician

Signature of Undertaker

Signature of Burial Society

Signature of Cemetery

Signature of Other

Signature of Health Officer

Signature of Board of Health

Signature of City Council

Signature of Mayor

Signature of State Health Officer

Signature of State Board of Health

Signature of State Council

Signature of Governor

Signature of Federal Health Officer

Signature of Federal Board of Health

Signature of Federal Council

Signature of President

Signature of Vice President

Signature of Speaker of House

Signature of Senate

Signature of Supreme Court

Signature of Justices

Signature of Judges

Signature of Clergy

Signature of Ministers

Signature of Priests

Signature of Rabbis

Signature of Imams

Signature of Other Religious Leaders

Signature of Scientists

Signature of Engineers

Signature of Lawyers

Signature of Other Professionals

Signature of Teachers

Signature of Students

Signature of Parents

Signature of Other Educators

Signature of Politicians

Signature of Activists

Signature of Artists

Signature of Other Public Figures

Signature of Media

Signature of Publishers

Signature of Distributors

Signature of Other Industry Leaders

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10550

10568

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			d. STREET ADDRESS 4008 37 Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Randolph Last Forrest			4. DATE OF DEATH Month Sept Day 2 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/18		9. AGE (In years lost birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Bladen Forrest			14. MOTHER'S MAIDEN NAME Henrietta Messinger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	INFORMANT Address Helen Lambden Sister 231-33St. NE Washington		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain cho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fatty metamorphosis of the liver DUE TO (c) Acute alcoholic intoxication					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bladensburg	(County) Maryland	(State) Md.
21. I certify that I attended the deceased from Aug 30 1959 to Sept 2 1959 that I last saw the deceased alive on Sept 2 1959 and that death occurred at 11:15 P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE William D. Rosson M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Road Bladensburg, Maryland			
PHYSICIAN'S NAME (Type) Dr. William D. Rosson		DATE SIGNED 9/3/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/7/59	22c. NAME OF CEMETERY OR CREMATORY Holy Rood Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. REC'D BY REGISTRAR SEP 8 '59			24b. REGISTRAR'S SIGNATURE Arthur L. Hines		

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077
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10551

10569

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Camden	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherbury		c. LENGTH OF STAY IN 1b 2 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey L Middle . Last Gaumer		4. DATE OF DEATH Month Sept. Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 July 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	11. IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Treasurer		10b. KIND OF BUSINESS OR INDUSTRY Dairy Co	
11. BIRTHPLACE (State or foreign country) Pennsauken		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME William Gaumer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/25 , 19 59 , to 9/27 , 19 59 , that I last saw the deceased alive on 9/26 , 19 59 , and that death occurred at 2:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4410 74 Ave DATE SIGNED 9/27/59 ACTUAL SIGNATURE Dr. F. Musser, M.D. M.D. Bellmeade Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Pennsauken New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

CERTIFICATE OF DEATH

0323

1933

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

10620

CERTIFICATE OF DEATH

10552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN 1b 23 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James H Middle James H Last Gaunt				4. DATE OF DEATH Month September Day 26 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasion		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 25, 1959	
9. AGE (In years lost birthday) yrs. 23		10. IF UNDER 1 YEAR Months 23 Days 15		11. IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Gaunt				14. MOTHER'S MAIDEN NAME LeeAnn Marie Voeltz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None			
INFORMANT Hospital Records				Address USAF Hospital, Andrews			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 23 Hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sep 25 , 19 59 , to September 26 , 19 59 , that I last saw the deceased alive on September 26 , 19 59 , and that death occurred at 0200A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Salvatore Battiatia M.D. USAF Hospital Andrews September 26, 59							
PHYSICIAN'S NAME (Type) SALVATORE BATTIATA Capt USAF MC USAF Hosp, Andrews Air Force Base, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 29, 1959		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Kimble Funeral Home				ADDRESS 816 N St, N.E. Wash, DC.		24a. REC'D BY REGISTRAR DATE SEP 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur & Thane			

2050222X00

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10553

Reg. Dist. No.

10570

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 15			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4948 37th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jonathon Frederick Gehman				4. DATE OF DEATH Month Day Year Sept 5, 1959			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-19		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post office		11. BIRTHPLACE (State or foreign country) Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur R. Gehman				14. MOTHER'S MAIDEN NAME Ida Frederick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Ida F. Behman; 3708 40th Place, Cottage City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cirrhosis of the liver (c)</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED Sept. 6, 1959			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-10-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10370

Name of Deceased		John A. Murphy	
Sex		Male	
Age		45	
Date of Birth		1880	
Place of Birth		New York	
Usual Residence		123 Main St., Boston	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date		Sept. 1, 1932	

1 ~~X~~ MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG249 10-9-59 et

10539

CERTIFICATE OF DEATH

Reg. Dist. No.

10554

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. Virginia b. COUNTY Prince Georges Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM I. GERNAND				4. DATE OF DEATH Month Day Year September 26 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/74	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Examiner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Patent Office Illinois			
11. BIRTHPLACE (State or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Abraham H. Gernand				14. MOTHER'S MAIDEN NAME Emma Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Decedent				Address --			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Thrombosis DUE TO (c) Cerebral Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days over 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 58 to Sept 26 19 59 that I last saw the deceased alive on Sept 26 19 59 and that death occurred at 9:30 PM M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis H. Shuman				ADDRESS (Street, city or town, state) 1635 Mass. Ave. N.W. Wash. D.C.			
PHYSICIAN'S NAME (Type) Louis H. Shuman				DATE SIGNED 9/26/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Home Co. 2901 K St. N.W. Wash. D.C.				24a. REC'D BY REGISTRAR SEP 30 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

GRAYSON, R. L. AND M. L. MATHIAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10555

10571

Item 12 Film 249 10-6-59 et

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69x3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 930 East 4th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Gilberto Granado				4. DATE OF DEATH Month Day Year September 24, 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-29-30	
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dish-washer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Santa Clara, Cuba	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Pastor Granado				14. MOTHER'S MAIDEN NAME Dolores Portieres			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO.		17. INFORMANT Felicidad Granado; same address as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral necrosis (Right parietal temporal area) (c) Old subdural hematoma DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto. Passenger in an automobile in collision with another			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2.45xxx 8-22-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Mitchellville Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 9-26-59		22c. NAME OF CEMETERY OR CREMATORY	
				22d. LOCATION (City, town, or county) New York, N.Y.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Fun Lee Funeral				ADDRESS Homme washington d.c.		24a. REC'D BY REGISTRAR DATE SEP 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur D. Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6531

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 1, 1950		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Examiner		Signature of Coroner		Signature of Physician	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10556

Reg. Dist. No.

10621

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 7 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Franz Middle Victor Last Greenfield			4. DATE OF DEATH Month September Day 13 Year 19 59				
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-19-59		9. AGE (In years last birthday) yrs. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Holley			14. MOTHER'S MAIDEN NAME Clementine Greenfield				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Clementine Greenfield; Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion							
492X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonitis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.			DATE SIGNED				
EXAMINER'S NAME (Type) John T. Maloney, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-59		22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery			
22d. LOCATION (City, town, or county) (State) Suitland, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Robert M. Quinn</i> 1870-9" NW 2077 293 X04 YR 45H.D.C			24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hines</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 7106 F. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle S. Last Gregory				4. DATE OF DEATH Month Sept Day 17 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/9/78	
9. AGE (In years lost birthday) yrs. 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John. W. Gregory				14. MOTHER'S MAIDEN NAME Emma. M. Lacy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT John Gregory Brother		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardio-Respiratory Failure DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized Arteriosclerosis DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1959 , to Sept. 17, 1959 , that I last saw the deceased alive on Sept 17 , 19 59 , and that death occurred at 11:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Max M. Herzberg		DATE 7-16-59		ADDRESS (Street, city or town, state) Seat Pleasant, Md.		DATE SIGNED 9-18-59	
PHYSICIAN'S NAME (Type) Dr. Herzberg							
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/21/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 300.4th.st N.E.				24a. REC'D BY REGISTRAR SEP 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10573

10573

CERTIFICATE OF DEATH

STATE OF MARYLAND

Blank form with faint lines and text, including fields for name, age, sex, race, date of death, and place of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10573

CERTIFICATE OF DEATH

Reg. Dist. No.

10558

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> <u>13x-2</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital</u>				d. STREET ADDRESS <u>229 Mission Road</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Hager</u> Last <u>Hager</u>				4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 19, 1959</u>			
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>35</u>		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>					
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Thomas Chester Hager</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis Opal Pennington</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Hospital Records</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>—</u> , 19 <u>—</u> , to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>									
ACTUAL SIGNATURE <u>Frank L. Weaver</u> M.D.									
PHYSICIAN'S NAME (Type) <u>Frank L. Weaver, M.D. 324 Montgomery Ave. Laurel, Maryland</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel General Hospital, Laurel, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

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CERTIFICATE OF DEATH

10733

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, MD

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

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10622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 1-Year	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2621- Kenton Place S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD First M. Middle HARRIS Last		4. DATE OF DEATH Sept. 26th. Month 1959 Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21st 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Chestnut Farm Dairy	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Harris		14. MOTHER'S MAIDEN NAME May Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Frankie L. Harris Same as # 2.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Coronary artery sclerosis. (b) Hypertensive arteriovascular disease DUE TO lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH Instant. 2-3 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 18, 1957 to Sept. 26, 1959 , that I last saw the deceased alive on Sept. 18, 1959 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney W. Lowry		ADDRESS (Street, city or town, state) 7200- Marlboro Pike S.E. Wash. 28, DC DATE SIGNED 9/26/59	
PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY		7200- Marlboro Pike S.E. Washington 28, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 30- 59	
22c. NAME OF CEMETERY OR CREMATORY Edgellawn		22d. LOCATION (City, town, or county) (State) Jamesport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers ADDRESS 1661- Good Hope Road S.E. Washington, D.C.		24a. RECEIVED BY REGISTRAR SEP 28 59 DATE	
24b. REGISTRAR'S SIGNATURE William J. Harris			

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10625 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt #1 Box 187		d. STREET ADDRESS Box 187	
3. NAME OF DECEASED (Type or print) Samuel Hawkins Sr		4. DATE OF DEATH Sept 2 1959	
5. SEX Male	6. COLOR OR RACE Negr	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Hawkins		14. MOTHER'S MAIDEN NAME Nancy G. G. G.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Elizabeth G. Hawkins		Address Lanham Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Hypertension DUE TO (c) Generalized Arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 yrs 6 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Henry A. Wise Jr		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Henry A. Wise Jr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 59	
22c. NAME OF CEMETERY OR CREMATORY Ascension Cemetery		22d. LOCATION (City, town, or county) (State) Bowie, Pr. Georges, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 1820-9th St NW WASH. DC, (1)	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE SEP 9 '59		C. L. King & House	

TO HOSPITAL OR FUNERAL DIRECTOR The law requires that the death certificate be executed within 24 h
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and
page 3 should be detached for use as the burial-transit permit. Then please

9383

CERTIFICATE OF DEATH

09408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		c. LENGTH OF STAY IN 1b 18 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		d. STREET ADDRESS 7015 Fordham Court	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7015 Fordham Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Paul Harold Heimer		4. DATE OF DEATH Month Day Year Sept. August 20 / 1. 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 11, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank L Heimer		14. MOTHER'S MAIDEN NAME Hattie Gibby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W W 1		16. SOCIAL SECURITY NO. INFORMANT Jean E Heimer College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Clark Canary Mumps 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Centricentric Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 46 , to 9-1 , 19 59 that I last saw the deceased alive on 12 , 19 57 , and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED SEP 2 1959			
ACTUAL SIGNATURE C. Deitz		M.D. Hyattsville, Md.	
PHYSICIAN'S NAME (Type) A Deitz			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4, 1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE SEP 4 '59	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hayes	

MEDICAL CERTIFICATION

completely filled in by the registrar, or removal, or cremation, or removal, and in any event within 72 hours after death. Remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

11

John A. Nelson

John A. Nelson

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10540

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN lb <u>6mo. 20days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 LASALLE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET T. Hickey</u>		4. DATE OF DEATH Month Day Year <u>September 14th 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12 1898</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hickey</u>		14. MOTHER'S MAIDEN NAME <u>HONORA CRONIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>S.M. Joseph Bernadette, D. Carm.</u>		Address <u>Carroll Manor</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Inanition</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>metastatic CA. of Rectum</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>58</u> , to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 14</u> , 19 <u>59</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Foster</u> M.D.		ADDRESS (Street, city or town, state) <u>1746 K St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES J. FOSTER</u>		DATE SIGNED <u>1746-K St. N.W. WASH.D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY, OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9-17-59</u>	<u>mt Olivet cemetery</u>	<u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. W. S. Thomas</u>

Page 4
death. The low requires that the death certificate be executed within 24 hours of death.
VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

18-40

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10562

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10574

1. PLACE OF DEATH a. Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley c. LENGTH OF STAY IN 1b 1/2 Hr. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen., Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vista d. STREET ADDRESS Box 99 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Estelle Last Howard		4. DATE OF DEATH Month Sept. Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27, 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Adaline White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Dorothy Mayo		1315 Lincoln Ave. Cinn., Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Multiple fractures of legs and fractured skull. (c) skull. DUE TO stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A pedestrian; struck by an automobile	
20c. TIME OF INJURY Month, Day, Year 10.50 Hour 9-7- 19 59 P. M.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Vista Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED Sept. 8, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-12-59	22c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL	22d. LOCATION (City, town, or county) (State) SUITLAND MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS		24a. REC'D BY REGISTRAR SEP 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. McNamee, Jr.		Male		34.5	
Date of Death		Place of Death		Cause of Death	
May 1, 1939		Home		Myocardial infarction	
Time of Death		Occupation		Manner of Death	
10:30 AM		None		Natural	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report	
May 1, 1939		Baltimore		Death	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10541

CERTIFICATE OF DEATH

10563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anneo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>same</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5704-31st Blvd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JOHN</i> First <i>PEARCE</i> Middle <i>HOWARD</i> Last		4. DATE OF DEATH <i>Sept 30</i> Month <i>30</i> Day <i>1959</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 8, 1884</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Penn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frederick A Howard</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Beaul</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-16-2262</i>	
17. INFORMANT <i>W. L. Etienne</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ac Congestive Heart Failure</i> 420.0 DUE TO <i>Chronic obstructive heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i>Chronic obstructive heart disease</i> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1959</i> to <i>Sept 30 1959</i> , that I last saw the deceased alive on <i>Aug 6 1959</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. L. Etienne</i>		DATE SIGNED <i>9/30/59</i>	
PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>		ADDRESS (Street, city or town, state) <i>4713-17th St College Park, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	22b. DATE THEREOF <i>9/30/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>Oct 1 '59</i>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10564

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tina Middle Marie Last Howey				4. DATE OF DEATH Month September Day 29 Year 1959			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-59	9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months 29	IF UNDER 24 HRS. Hours 29 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Charles Truitt Howey			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Charles T. Howey; same address as # 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 492x DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute pneumonitis (c) Acute pneumonitis (c) Acute pneumonitis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10/1/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		
23. FUNERAL DIRECTOR'S SIGNATURE Francis Baschi Sone			ADDRESS Hyattsville Md		24a. REC'D BY REGISTRAR Oct 1 '59		
					24b. REGISTRAR'S SIGNATURE Arthur A. Huns		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10624

CERTIFICATE OF DEATH

Reg. Dist. No. 11728

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington 47x-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 6 mo, 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1522 - D. St., S.E.			
3. NAME OF DECEASED (Type or print) Chester Jefferson				4. DATE OF DEATH Month Sept. Day 30 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/89		9. AGE (In years last birthday) yrs. 70	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus Jefferson				14. MOTHER'S MAIDEN NAME Fannie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-6936		INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr., 2 mo's	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/10/ 19 59 , to 9/30 19 59 , that I last saw the deceased alive on September 30 19 59 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital, Maryland DATE SIGNED 9/30/59 ACTUAL SIGNATURE Moe Weiss PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/5/59		22c. NAME OF CEMETERY OR CREMATORY WOOD LAWN		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Alexander S Pope		ADDRESS 414-15th, N.E.		24a. REC'D BY REGISTRAR DATE OCT 8 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/28

CERTIFICATE OF DEATH

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10576

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 26 1/2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raynar Middle Johnson Last Johnson				4. DATE OF DEATH Month Sept Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/59	9. AGE (In years last birthday) 7 yrs.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United states	
13. FATHER'S NAME Richard Blake				14. MOTHER'S MAIDEN NAME Shirley Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Shirley Mother Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 Dehydration DUE TO Transition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sept 19, 19 59		20g. (County) Sept 20, 19 59		20h. (State) Sept 20, 19 59		20i. (City or town) Sept 20, 19 59	
21. I certify that I attended the deceased from Sept 19, 19 59 to Sept 20, 19 59 , that I last saw the deceased alive on Sept 20, 19 59 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. John Perkins M.D.				ADDRESS (Street, city or town, state) 5301 Hamilton St, Hyattsville 9/19/59			
PHYSICIAN'S NAME (Type)				DATE SIGNED 9/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-25-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem -		22d. LOCATION (City, town, or county) Brimm Rd SE-NC	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 467 N st NW		24a. REC'D BY REGISTRAR SEP 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Krasik							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS
DEPARTMENT OF HEALTH

CASE

Name of Patient		Age		Sex		Race		Religion		Marital Status		Occupation		Address		City		County		State	
John Doe		35		Male		White		Catholic		Single		Teacher		123 Main St		Houston		Harris		Texas	
Date of Birth		Date of Admission		Date of Discharge		Date of Death		Cause of Death		Place of Death		Time of Death		Time of Admission		Time of Discharge		Time of Death		Time of Admission	
1945-01-01		1945-01-01		1945-01-01		1945-01-01		Heart Disease		Home		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Previous History		Present History		Past History		Family History		Social History		Physical Examination		Laboratory Tests		X-ray		Pathology		Microbiology		Immunology	
None		Cough, Sputum		Fever, Chills		None		Smoking, Alcohol		Normal		Normal		Normal		Normal		Normal		Normal	
Treatment		Prognosis		Disposition		Follow-up		Remarks		Signature of Doctor		Signature of Nurse		Signature of Pharmacist		Signature of Pathologist		Signature of Microbiologist		Signature of Immunologist	
Medication		Diet		Activity		Education		Counseling		John Doe, M.D.		Jane Doe, R.N.		John Doe, Pharm.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.	

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10547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4230--34th Street-				d. STREET ADDRESS 4230--34th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle ISAAC Last JONES				4. DATE OF DEATH Month Sept. Day 10th, Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5th, 1872	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder & Contractor				10b. KIND OF BUSINESS OR INDUSTRY Homes, etc.		11. BIRTHPLACE (State or foreign country) Orange County, Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James M. Jones				14. MOTHER'S MAIDEN NAME Lucy Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-09-1476			
17. INFORMANT Irene A. Garvey, 1500 Montana Ave., N.E. Washington, D.C.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arterial Thrombosis DUE TO Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days years. years.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.				20g. (County) Prince Georges		20h. (State) Md.	
21. I certify that I attended the deceased from June 1950 , to 9/10/1959 , that I last saw the deceased alive on Sept 10, 1959 , and that death occurred at 5:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 335--W--St. N.E. Washington, D.C. DATE SIGNED 9/10/1959							
ACTUAL SIGNATURE Char. V. Pate				M.D. 335--W--St. N.E. Washington, D.C.			
PHYSICIAN'S NAME (Type) Charles V. Pate							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10567

10577

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley c. LENGTH OF STAY IN 1b 3Hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi d. STREET ADDRESS 8706 23rd Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Paul Kemerer		4. DATE OF DEATH Month Day Year Sept. 7 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Nov 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME William J. Kemerer		14. MOTHER'S MAIDEN NAME Matilda Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. George Anna Kemerer INFORMANT Address (Wife) Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4571x DUE TO Refrigerated Abdominal Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. } DUE TO Generalized Arteriosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-1 , 19 45 , to 9-7 , 19 59 , that I last saw the deceased alive on 9-7 , 19 59 , and that death occurred at 2:45P M, from the causes and on the date stated above. ACTUAL SIGNATURE A Deitz M.D. Hyattsville Md. PHYSICIAN'S NAME (Type) A Deitz ADDRESS (Street, city or town, state) Hyattsville Md. DATE SIGNED 9-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/59	22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		22d. LOCATION (City, town, or county) (State) Hyattsville Maryland.	
24a. REC'D BY REGISTRAR DATE SEP 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10578

CERTIFICATE OF DEATH

Reg. Dist. No.

10568

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S CO. HOSP.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 WEST HYATTSVILLE	
		d. STREET ADDRESS 5901- 33rd AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERBERT Middle D. Last KETCHUM		4. DATE OF DEATH Month 9 Day 8 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/96
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store clerk Atchison & Keller		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Gatto	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Eva T. Ketchum		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma with metastases 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1, 1957 , to 9/8, 1959 , that I last saw the deceased alive on 9/7, 1959 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 New York Ave NW Washington D.C. DATE SIGNED 9/8/59 ACTUAL SIGNATURE R.S. Williams M.D. PHYSICIAN'S NAME (Type) R.S. WILLIAMS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/11/59	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE SEP 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur & Hines			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adelene Middle Last King		4. DATE OF DEATH Month Sept. Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1918 Sept. 2, 1932
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House maid		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S. A		12. CITIZEN OF WHAT COUNTRY? U.S. A	
13. FATHER'S NAME Arthur King		14. MOTHER'S MAIDEN NAME Estelle Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-34-3751	
INFORMANT Estelle King, Prince Frederick, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 561.2 DUE TO (b) Uncalcified umbilical hernia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary atelectasis INTERVAL BETWEEN ONSET AND DEATH 5 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-27 , 19 59 , to 9-6 , 19 59 , that I last saw the deceased alive on 9-6 59 , 19 59 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Kennedy Skipton M.D.		ADDRESS (Street, city or town, state) 7220 Forest Road Kent Village, Md.	
PHYSICIAN'S NAME (Type) Dr. Kennedy Skipton M.D.		DATE SIGNED	
22a. BURIAL CREMATION, REMOVAL (Specify) 9-9-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY mt. Olive		22d. LOCATION (City, town, or county) (State) calvert co. md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell		24a. REC'D BY REGISTRAR DATE SEP 11 '59	
ADDRESS Prince Frederick		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10550

CERTIFICATE OF DEATH

Name of deceased: [illegible] Date of death: [illegible]

Place of death: [illegible]

Age of deceased: [illegible] Sex: [illegible]

Occupation: [illegible]

Signature of physician: [illegible]

Signature of registrar: [illegible]

Signature of informant: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

Signature of witness: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10580

10570

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 1/2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tiawana Middle Landis Last Landis				4. DATE OF DEATH Month Sept Day 20 Year 19 59			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4 59	
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 12 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mamie Landis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Ethel Grand-Mother Address Address same				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Enterocolitis (clinical) DUE TO (c) Enterocolitis (clinical) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Sept 20 , 19 59 , to Sept 20 , 19 59 , that I last saw the deceased alive on Sept 20 , 19 59 , and that death occurred at 5P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville DATE SIGNED 9/19/59			
PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Sep-24-1959				22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			
22d. LOCATION (City, town, or county) (State) Washington D. C.				23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. ADDRESS 3015 12th St., N. E.			
24a. REC'D BY REGISTRAR SEP 23 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

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doi:10.1017/S002229240000251

John T. Williams & Co., Ltd., 2, Abchurch Lane, London, E.C. 4, ENGLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
Item 18 Film 249 10-5-59 ams																			
10542																			
CERTIFICATE OF DEATH																			
Reg. Dist. No. 10571																			
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE					c. LENGTH OF STAY IN 1b Since Nov. 1957					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 1556-2									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR					d. STREET ADDRESS 4922 LANSALLE ROAD					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) MARTHA BENTON					4. DATE OF DEATH SEPT. 18 1959														
5. SEX F		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/78		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS					10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE					11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME HENRY BENTON JOHN LEE					14. MOTHER'S MAIDEN NAME ALICE RILEY														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 214-03 9763					INFORMANT Mr. Daniel J. Lee, Jr., 749 Thayer Ave. Silver Spring, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CONGESTIVE HEART FAILURE DUE TO Arterial hypertension (had intracranial accident) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) SEPTICEMIA DUE TO (c) POST OPERATIVE WOUND INFECTION										INTERVAL BETWEEN ONSET AND DEATH 96 HRS. 6 DAYS									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TERMINAL PNEUMONIA, PROBABLE CEREBRAL VASCULAR ACCIDENT										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE														
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 19 48 to 18 SEP 1959 , that I last saw the deceased alive on 11 SEP 1959 , and that death occurred at 12:25 PM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 1407 WOODSIDE PKWY SILVER SPRING MD.					DATE SIGNED 18 SEP 59				
ACTUAL SIGNATURE L. Marshall Cuvillier M.D.																			
PHYSICIAN'S NAME (Type) L. MARSHALL CUVILLIER																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 9/21/59					22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY					22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.				
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska					ADDRESS SILVER SPRING, MD.					24a. REC'D BY REGISTRAR DATE SEP 23 '59					24b. REGISTRAR'S SIGNATURE Carlton S. Kline				

CERTIFICATE OF DEATH



STATE OF NEW YORK
COUNTY OF [illegible]

19[illegible]
[illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10543

CERTIFICATE OF DEATH

10572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Hyattsville Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arlington, Virginia b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, MD.		c. LENGTH OF STAY IN 1b Two years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home		e. STREET ADDRESS 2419 North Powhatan	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle M. Last Lehning		4. DATE OF DEATH Month September Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 23	11. IF UNDER 24 HRS. Hours 23 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Lauder		14. MOTHER'S MAIDEN NAME Maria O'Meara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 121-09-0870D	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive heart Disease DUE TO 2 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1958 , to Sept 21, 1959 , that I last saw the deceased alive on Sept 20, 1959 , and that death occurred at 9:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9-55-59 DATE SIGNED			
ACTUAL SIGNATURE Thomas F. Collins		PHYSICIAN'S NAME (Type) THOMAS F. COLLINS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-22-59	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) New York, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS Wash. D. C.	
24a. REC'D BY REGISTRAR SEP 24 59		24b. REGISTRAR'S SIGNATURE Arthur J. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
10381

10573

10381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY Barnstable	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Station Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Steve Sture Waldemar Lofgren		4. DATE OF DEATH Month Sept. Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Dec 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dyer		10b. KIND OF BUSINESS OR INDUSTRY Cloth	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Lofgren		14. MOTHER'S MAIDEN NAME Carolina ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 010 072 124	
17. INFORMANT Betty A. Lofgren (Wife) Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/1/59	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR OCT 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur A. Hines			

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John A. Sullivan		SEX Male	
DATE OF BIRTH 1881		AGE 37	
PLACE OF BIRTH Ireland		OCCUPATION Laborer	
RESIDENCE 123 Main St., Boston, Mass.		CAUSE OF DEATH Heart Disease	
MEDICAL HISTORY None		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		DATE 1918	

10625

CERTIFICATE OF DEATH

Reg. Dist. No.

10574

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3116 Ramblewood Dr.				d. STREET ADDRESS 3116 Ramblewood Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		First G Middle McMahon Last		4. DATE OF DEATH Sept 5 1959		Month Sept Day 5 Year 1959	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 May 59		9. AGE (In years last birthday) N/A yrs.	IF UNDER 1 YEAR 3 Months 5 Days	IF UNDER 24 HRS. — Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J McMahon				14. MOTHER'S MAIDEN NAME Ann Dorion			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		INFORMANT Thomas J McMahon Address 3116 Ramblewood Dr. District Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease (c) Mongolism						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 May , 19 59 , to 3 Sep , 19 59 , that I last saw the deceased alive on 3 Sep , 19 59 , and that death occurred at UNK M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John A Moore				ADDRESS (Street, city or town, state) USAF HOSP ANDREWS AAFB WASH DC DATE SIGNED 5 Sep 59			
PHYSICIAN'S NAME (Type) John A Moore Capt USAF (MC)				USAF HOSP ANDREWS AAFB WASH DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9, 1959		22c. NAME OF CEMETERY OR CREMATORY Arkington National		22d. LOCATION (City, town, or county) (State) Arkington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Kinellie Ford Howe ADDRESS 816 H.D., N.E. & C.				24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Carlton L. Hines	

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1

40x9x2.50

CERTIFICATE OF DEATH

10626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <u>D.C.</u> b. COUNTY <u>Prince Georges</u> <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>		c. LENGTH OF STAY IN 1b <u>23 Hrs 40 Min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews Air Force Base Washington 20</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>				d. STREET ADDRESS <u>3412 19th St., S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NewBorn</u> Middle <u>McPherson</u> Last <u>McPherson</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Mongolian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 16 1959</u>	
9. AGE (In years last birthday) yrs. <u>23</u>		IF UNDER 1 YEAR Months <u>23</u> Days <u>40</u>		IF UNDER 24 HRS. Hours <u>23</u> Min. <u>40</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dempster E McPherson</u>				14. MOTHER'S MAIDEN NAME <u>Miyoko Kashima</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>See Sec 13</u>		Address <u>3412 19th SE Wash 20 D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature Birth</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>23 Hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 16 1959</u> to <u>September 17 1959</u> , that I last saw the deceased alive on <u>September 17 1959</u> , and that death occurred at <u>04:25A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USAF Hospital Andrews</u> DATE SIGNED <u>Sep 17, 59</u>							
ACTUAL SIGNATURE <u>John A Moore</u>				M.D. <u>USAF Hospital Andrews</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A MOORE Capt USAF MC</u>				<u>USAF Hospital Andrews Air Force Base, Wash 25, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>District of Columbia Morgue, Washington, D. C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>---</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10573

CENTRAL BUREAU OF DEATHS

10573

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10627

CERTIFICATE OF DEATH

10578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Land Over Hills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Land Over Hills, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7409 Upshur Street		e. STREET ADDRESS 7409 Upshur Street	
3. NAME OF DECEASED (Type or print) First Margaret Middle Brookman Last Morris		4. DATE OF DEATH Month Sept. Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1877
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months 13 Days 13 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Brookman Wall		14. MOTHER'S MAIDEN NAME Louisa Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Emily Morris	
17. INFORMANT 7409 Upshur St.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive FAILURE 420.0 DUE TO Arterio-Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 years. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23- 19 59 , to 9-13- 19 59 , that I last saw the deceased alive on 9-11- 19 59 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert Roth		ADDRESS (Street, city or town, state) 5510 Madison St. Riverdale, Md.	
PHYSICIAN'S NAME (Type) Albert Roth		DATE SIGNED 9/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/16/59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 2901 14th St. N.W. The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Md			c. LENGTH OF STAY IN 1b 7 months		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bell Nursing Home			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Md.		
f. STREET ADDRESS 5912 Le May Road			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Craig Last Morrison			4. DATE OF DEATH Month Sept Day 30 Year 19 59-		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 24, 1959		9. AGE (In years lost birthday) yrs. 7 Months 7 Days 7 Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME James L. Morrison		
14. MOTHER'S MAIDEN NAME Barbara P Helmer			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. none			17. INFORMANT Bell Nursing Home West Hyattsville Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal broncho pneumonia 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Upper Resp infection DUE TO (c) mongolism with congenital heart disease					INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days birth on
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 7/30/59 to 9/30/59 that I last saw the deceased alive on 9/30/59 , 19 59 , and that death occurred at 4 P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Thomas A. Christensen		ADDRESS (Street, city or town, state) College Park, Md.		DATE SIGNED 10/1/59	
PHYSICIAN'S NAME (Type) Thomas A Christensen					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/2/59	22c. NAME OF CEMETERY OR CREMATORY George Washington	22d. LOCATION (City, town, or county) (State) Hyattsville Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE OCT 5 2 '59		
			24b. REGISTRAR'S SIGNATURE Arthur E. Kinn		

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10582
CERTIFICATE OF DEATH

10578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 hrs. 15 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1022 University Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nora M. Nasella		4. DATE OF DEATH Month Day Year September 16 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1909
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anible Nasella		14. MOTHER'S MAIDEN NAME Julia H. Dugan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Victoria M. Nasella		Address 1022 University Blvd., East Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO pancreatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) lymphatic carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 16, 1959 to Sept 16, 1959 that I last saw the deceased alive on Sept 16, 1959 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Rosson M.D.		DATE SIGNED 9/17/59	
PHYSICIAN'S NAME (Type) Dr. William Rosson		ADDRESS (Street, city or town, state) 5304 Annapolis Road, Bladensburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/21/59	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE SEP 21 '59	
24b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10628

CERTIFICATE OF DEATH

10579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roger Heights Md		c. LENGTH OF STAY IN 1b 13 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Roger Heights Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5027 54th Place		d. STREET ADDRESS 5027 54th place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle NICHOLTS Last OLIVER		4. DATE OF DEATH Month September Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 22, 1915
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Pasquale Oliver		14. MOTHER'S MAIDEN NAME Theresa Barone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W 11		16. SOCIAL SECURITY NO.	
17. INFORMANT Adella E Oliver Roger Heights Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis to lungs + pleurae DUE TO (c) 1 yr		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March, 1959 , to Sept 2, 1959 , that I last saw the deceased alive on August 28, 1959 , and that death occurred at 6:40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Rosson M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Road Baltimore, Maryland	
DATE SIGNED			
PHYSICIAN'S NAME (Type) William D. Rosson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/5/59	22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	22d. LOCATION (City, town, or county) (State) Hanover Township Pa.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE Civilian & Kinn	

CERTIFICATE OF DEATH

1922

Page 2 of 2

Name of Deceased [Illegible]		Sex [Illegible]		Age [Illegible]	
Date of Birth [Illegible]		Place of Birth [Illegible]		Usual Residence [Illegible]	
Date of Death [Illegible]		Place of Death [Illegible]		Usual Residence [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]		Signature of Physician [Illegible]	
Signature of Registrar [Illegible]		Signature of Coroner [Illegible]		Signature of Medical Examiner [Illegible]	

August 28 29
 11 am 1922

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10580

Reg. Dist. No.

10629

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3339 Buchanan Street				d. STREET ADDRESS 3339 Buchanan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Walter Middle Theodore Last Owens				4. DATE OF DEATH Month Sept. Day 26 Year 1959				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-14		
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 45 Days 45		IF UNDER 24 HRS. Hours 45 Min. 45				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier			10b. KIND OF BUSINESS OR INDUSTRY Post office		11. BIRTHPLACE (State or foreign country) Dist of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore James Owens				14. MOTHER'S MAIDEN NAME Edna Mae Barnes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-09-5920		17. INFORMANT Walter T. Owens, Jr.				
				Address 5406 Hamilton St. Hyattsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 462.1 DUE TO Rupture of esophageal varix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema and congestion; Cerebral edema and congestion</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED				
EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 27, 1959				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE 30 1959		
						24b. REGISTRAR'S SIGNATURE C. S. S. S.		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Juror		12. Signature of Witness	
13. Signature of Physician		14. Signature of Nurse		15. Signature of Chaplain	
16. Signature of Undertaker		17. Signature of Funeral Home		18. Signature of Cemetery	
19. Signature of Burial Place		20. Signature of Interment		21. Signature of Burial	
22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
25. Signature of Burial		26. Signature of Burial		27. Signature of Burial	
28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial	
34. Signature of Burial		35. Signature of Burial		36. Signature of Burial	
37. Signature of Burial		38. Signature of Burial		39. Signature of Burial	
40. Signature of Burial		41. Signature of Burial		42. Signature of Burial	
43. Signature of Burial		44. Signature of Burial		45. Signature of Burial	
46. Signature of Burial		47. Signature of Burial		48. Signature of Burial	
49. Signature of Burial		50. Signature of Burial		51. Signature of Burial	
52. Signature of Burial		53. Signature of Burial		54. Signature of Burial	
55. Signature of Burial		56. Signature of Burial		57. Signature of Burial	
58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial	
64. Signature of Burial		65. Signature of Burial		66. Signature of Burial	
67. Signature of Burial		68. Signature of Burial		69. Signature of Burial	
70. Signature of Burial		71. Signature of Burial		72. Signature of Burial	
73. Signature of Burial		74. Signature of Burial		75. Signature of Burial	
76. Signature of Burial		77. Signature of Burial		78. Signature of Burial	
79. Signature of Burial		80. Signature of Burial		81. Signature of Burial	
82. Signature of Burial		83. Signature of Burial		84. Signature of Burial	
85. Signature of Burial		86. Signature of Burial		87. Signature of Burial	
88. Signature of Burial		89. Signature of Burial		90. Signature of Burial	
91. Signature of Burial		92. Signature of Burial		93. Signature of Burial	
94. Signature of Burial		95. Signature of Burial		96. Signature of Burial	
97. Signature of Burial		98. Signature of Burial		99. Signature of Burial	
100. Signature of Burial		101. Signature of Burial		102. Signature of Burial	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10583

CERTIFICATE OF DEATH

Reg. Dist. No.

10581

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills d. STREET ADDRESS 6814 Emerson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alma Middle Virginia Last Parrish		4. DATE OF DEATH Month Sept. Day 2 Year 19 59							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 March 1926	9. AGE (In years lost birthday) 33 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 3	12. IF UNDER 24 HRS. Hours 15	13. IF UNDER 24 HRS. Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Edgar Talbott				14. MOTHER'S MAIDEN NAME Agnes Phelps					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		INFORMANT William Parrish Address Landover Hills, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute spasm to the coronary artery 15 minutes. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholelithiasis INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-9- , 19 59 , to 9-2 , 19 59 , that I last saw the deceased alive on 9-1 , 19 59 , and that death occurred at 5, 10 A. M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Sam Schwartzbach		ADDRESS (Street, city or town, state) 1726 I ST., N.W. Washington 6, D.C. DATE SIGNED 9/2/59							
PHYSICIAN'S NAME (Type) Dr. Saul Segwartzbach		Washington D. C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 95/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ga sch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

CERTIFICATE OF DEATH

10281

Mar. 1944

Mar. 1944

Mar. 1944

Mar. 1944

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Mar. 1944

10630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 4 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle W Last PASCOE				4. DATE OF DEATH Month SEPTEMBER Day 10 Year 1959			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 24, 1906	
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 4 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER COLONEL				10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME CHARLES PASCOE				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1935 TO DATE				16. SOCIAL SECURITY NO. 113-012-302			
17. INFORMANT WILLIAM W PASCOE JR				3620 GUNSTON ROAD ARLINGTON, VIRGINIA			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA LUNG, LEFT DUE TO (c) 4 MONTHS							INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from APRIL , 19 59 , to 10 SEP , 19 59 , that I last saw the deceased alive on 9 SEP , 19 59 , and that death occurred at 9:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF HOSP ANDREWS, ANDREWS AFB 10 SEP 59 DATE SIGNED ACTUAL SIGNATURE Phillips A. Cox M.D. PHYSICIAN'S NAME (Type) PHILLIPS A COX LT COL USAF MC USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		SEPT. 14, 1959		ARLINGTON NATIONAL		ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Lincoln Funeral Home Inc.				ADDRESS 816 H St. NE. DC		24a. REC'D BY REGISTRAR DATE SEP 14 '59	
						24b. REGISTRAR'S SIGNATURE Arthur E. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10080

Blank form with faint horizontal lines for text entry.

10631

CERTIFICATE OF DEATH

10583

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bonlevard Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bonlevard Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2704-49 Avenue SE</u>		d. STREET ADDRESS <u>2704-49 Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Petrella</u> Middle <u>John</u> Last		4. DATE OF DEATH <u>Sept 22-1959</u> Month <u>Sept</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-1902</u>
9. AGE (In years, months, days) <u>56</u> yrs.		10. IF UNDER 1 YEAR <u>56</u> Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Niccolo Petrella</u>		14. MOTHER'S MAIDEN NAME <u>Terese De Marco</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>392-09-8060</u>	
17. INFORMANT <u>Terese Petrella</u>		Address <u>same as 12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial infarction</u> DUE TO (c) <u>2 hours</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Urinary Bladder</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-14-59</u> , 19 <u>59</u> , to <u>9-22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-16-59</u> , 19 <u>59</u> , and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul B. Bender</u>		ADDRESS (Street, city or town, state) <u>1150 Connaught N. Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Paul B. Bender, M.D.</u>		DATE SIGNED <u>9-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Switzland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Mattingly</u>		ADDRESS <u>131-11 St Wash DC</u>	
24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Largo		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7903 Whitehouse Road			
3. NAME OF DECEASED (Type or print) First Annette Middle Pinkney Last Pinkney				4. DATE OF DEATH Month September Day 20 Year 19 59			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-59		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days less 2 Hours 2 Min. days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Pinkney				14. MOTHER'S MAIDEN NAME Dorothea Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Dorothea Pinkney; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus with meningocele 752X DUE TO Conditions, if any, which gave rise to immediate cause (b) --- (c), stating the underlying cause lost. DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 20, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-23-59		22c. NAME OF CEMETERY OR CREMATORY Halt Family Cmn.		22d. LOCATION (City, town, or county) (State) Woodmore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Nancy Washington				ADDRESS 467 N. of N.W.		24a. REC'D BY REGISTRAR SEP 24 '59	
				24b. REGISTRAR'S SIGNATURE Arthur J. Kane			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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10585

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b (9Hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Proctor Middle Last		4. DATE OF DEATH Sept 19 19 59 Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/ 16 /59
9. AGE (In years lost birthday) yrs. 6 3		10. IF UNDER 1 YEAR Months 6 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles H Proctor		14. MOTHER'S MAIDEN NAME Mary Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None Address Mary E. Proctor Rt. 2, Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 18 19 59 to Sept 19 19 59 , that I last saw the deceased alive Sept 19 19 59 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		DATE SIGNED 9/19/59	
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.		ADDRESS (Street, city or town, state) 5301 Hamlet St., Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-23-59	22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Church	22d. LOCATION (City, town, or county) (State) Oxen Hill, Md
23. FUNERAL DIRECTOR'S SIGNATURE JOHN T. RHINES & CO By Robert C. Rhines		24a. REC'D BY REGISTRAR SEP 23 '59 DATE	
ADDRESS 3015 12th St N. E. Washington, D. C.		24b. REGISTRAR'S SIGNATURE Arthur S. King	

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Journal of Management Education 36(8)

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10586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Genral Hospbtal				e. STREET ADDRESS 18 Md.Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willoughby Middle L. Last Pugh				4. DATE OF DEATH Month Sept. Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Mar. 1890	
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office worker				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William Pugh				14. MOTHER'S MAIDEN NAME Laura V Pugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. Virginia Royalty		Address Parkland Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bladensburg				(County) Prince Georges		(State) Md.	
21. I certify that I attended the deceased from Sept 7 , 19 59 , to Sept 7 , 19 59 , that I last saw the deceased alive on Sept 7 , 19 59 , and that death occurred at 6:20A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson				DATE SIGNED 9/7/59			
PHYSICIAN'S NAME (Type) Dr. William D. Rosson				ADDRESS (Street, city or town, state) 5304 Annapolis Road			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 10, 1959		22c. NAME OF CEMETERY OR CREMATORY St Georges Cemetery	
22d. LOCATION (City, town, or county) Glenn Dale, Md.				(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR SEP 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10286

John J. Jones

John J. Jones

Admission 28 0.0.

28 0.0.

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John J. Jones
Admission 28 0.0.

John J. Jones
Admission 28 0.0.

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28 0.0.

10587

VS. A15ME(5)
5M 9/55

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		M		45		JAN 15 1900		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS	
JAN 15 1945		HOSPITAL		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		10 DAYS	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
10:00 AM		10		00		00		98.6		72		20		120/80	
NAME OF PHYSICIAN		NAME OF NURSE		NAME OF ATTENDING PHYSICIAN		NAME OF ASSISTANT PHYSICIAN		NAME OF PATHOLOGIST		NAME OF FORENSIC EXAMINER		NAME OF MEDICAL EXAMINER		NAME OF JURY	
DR. J. J. JONES		MISS J. J. JONES		DR. J. J. JONES		DR. J. J. JONES		DR. J. J. JONES		DR. J. J. JONES		DR. J. J. JONES		DR. J. J. JONES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF ATTENDING PHYSICIAN		SIGNATURE OF ASSISTANT PHYSICIAN		SIGNATURE OF PATHOLOGIST		SIGNATURE OF FORENSIC EXAMINER		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF JURY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		CITY OF CERTIFICATE		STATE OF CERTIFICATE		COUNTRY OF CERTIFICATE		CAUSE OF CERTIFICATE		MANNER OF CERTIFICATE		DURATION OF CERTIFICATE	
JAN 15 1945		HOSPITAL		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		10 DAYS	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10588

10632

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery County 1556.2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Adelphi		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8206 New Hampshire Silver Spring Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Branch Nursing Home		d. STREET ADDRESS 8206 New Hampshire Ave	
3. NAME OF DECEASED (Type or print) Bertha First Katherine Middle Luiseberry Last		4. DATE OF DEATH Sept. 7 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1882
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ezra H. Lowman		14. MOTHER'S MAIDEN NAME Lydia M. Messick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Nursing Home Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Left ventricular failure DUE TO (c) Cerebral Vascular Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-1, 1959, to 9-7, 1959, that I last saw the deceased alive on 9-6, 1959, and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. H. Sandstrom		ADDRESS (Street, city or town, state) 25 Lee Ave, Takoma Park, Md	
PHYSICIAN'S NAME (Type) R. H. Sandstrom		DATE SIGNED 9-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 9-7-59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Roanoke County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 11 '59	
		24b. REGISTRAR'S SIGNATURE Clifton S. Frank	

• **1992** – **1993** – **1994** – **1995** – **1996** – **1997** – **1998** – **1999** – **2000** – **2001** – **2002** – **2003** – **2004** – **2005** – **2006** – **2007** – **2008** – **2009** – **2010** – **2011** – **2012** – **2013** – **2014** – **2015** – **2016** – **2017** – **2018** – **2019** – **2020** – **2021** – **2022** – **2023** – **2024** – **2025** – **2026** – **2027** – **2028** – **2029** – **2030** – **2031** – **2032** – **2033** – **2034** – **2035** – **2036** – **2037** – **2038** – **2039** – **2040** – **2041** – **2042** – **2043** – **2044** – **2045** – **2046** – **2047** – **2048** – **2049** – **2050** – **2051** – **2052** – **2053** – **2054** – **2055** – **2056** – **2057** – **2058** – **2059** – **2060** – **2061** – **2062** – **2063** – **2064** – **2065** – **2066** – **2067** – **2068** – **2069** – **2070** – **2071** – **2072** – **2073** – **2074** – **2075** – **2076** – **2077** – **2078** – **2079** – **2080** – **2081** – **2082** – **2083** – **2084** – **2085** – **2086** – **2087** – **2088** – **2089** – **2090** – **2091** – **2092** – **2093** – **2094** – **2095** – **2096** – **2097** – **2098** – **2099** – **2100** – **2101** – **2102** – **2103** – **2104** – **2105** – **2106** – **2107** – **2108** – **2109** – **2110** – **2111** – **2112** – **2113** – **2114** – **2115** – **2116** – **2117** – **2118** – **2119** – **2120** – **2121** – **2122** – **2123** – **2124** – **2125** – **2126** – **2127** – **2128** – **2129** – **2130** – **2131** – **2132** – **2133** – **2134** – **2135** – **2136** – **2137** – **2138** – **2139** – **2140** – **2141** – **2142** – **2143** – **2144** – **2145** – **2146** – **2147** – **2148** – **2149** – **2150** – **2151** – **2152** – **2153** – **2154** – **2155** – **2156** – **2157** – **2158** – **2159** – **2160** – **2161** – **2162** – **2163** – **2164** – **2165** – **2166** – **2167** – **2168** – **2169** – **2170** – **2171** – **2172** – **2173** – **2174** – **2175** – **2176** – **2177** – **2178** – **2179** – **2180** – **2181** – **2182** – **2183** – **2184** – **2185** – **2186** – **2187** – **2188** – **2189** – **2190** – **2191** – **2192** – **2193** – **2194** – **2195** – **2196** – **2197** – **2198** – **2199** – **2200** – **2201** – **2202** – **2203** – **2204** – **2205** – **2206** – **2207** – **2208** – **2209** – **2210** – **2211** – **2212** – **2213** – **2214** – **2215** – **2216** – **2217** – **2218** – **2219** – **2220** – **2221** – **2222** – **2223** – **2224** – **2225** – **2226** – **2227** – **2228** – **2229** – **2230** – **2231** – **2232** – **2233** – **2234** – **2235** – **2236** – **2237** – **2238** – **2239** – **2240** – **2241** – **2242** – **2243** – **2244** – **2245** – **2246** – **2247** – **2248** – **2249** – **2250** – **2251** – **2252** – **2253** – **2254** – **2255** – **2256** – **2257** – **2258** – **2259** – **2260** – **2261** – **2262** – **2263** – **2264** – **2265** – **2266** – **2267** – **2268** – **2269** – **2270** – **2271** – **2272** – **2273** – **2274** – **2275** – **2276** – **2277** – **2278** – **2279** – **2280** – **2281** – **2282** – **2283** – **2284** – **2285** – **2286** – **2287** – **2288** – **2289** – **2290** – **2291** – **2292** – **2293** – **2294** – **2295** – **2296** – **2297** – **2298** – **2299** – **2300** – **2301** – **2302** – **2303** – **2304** – **2305** – **2306** – **2307** – **2308** – **2309** – **2310** – **2311** – **2312** – **2313** – **2314** – **2315** – **2316** – **2317** – **2318** – **2319** – **2320** – **2321** – **2322** – **2323** – **2324** – **2325** – **2326** – **2327** – **2328** – **2329** – **2330** – **2331** – **2332** – **2333** – **2334** – **2335** – **2336** – **2337** – **2338** – **2339** – **2340** – **2341** – **2342** – **2343** – **2344** – **2345** – **2346** – **2347** – **2348** – **2349** – **2350** – **2351** – **2352** – **2353** – **2354** – **2355** – **2356** – **2357** – **2358** – **2359** – **2360** – **2361** – **2362** – **2363** – <

15247

CERTIFICATE OF DEATH

Reg. Dist. No.

10589

10588

1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1Mo. 28 Days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince George				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last Julia La Roque Randall				4. DATE OF DEATH Month Day Year Sept. 25 19 59																			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNK		9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Self				11. BIRTHPLACE (State or foreign country) MINNESOTA				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME THOMAS Joseph LA ROQUE								14. MOTHER'S MAIDEN NAME ELIZABETH JENG															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. INFORMANT				Address THOMAS Phillip LA Roque															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 730.2 DUE TO Multiple abscesses Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Osteomyelitis of right foot (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus												INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks 2 months											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from Aug. 27 , 19 59 , to Sept. 25 , 19 59 , that I last saw the deceased alive on Sept. 25 , 59 , and that death occurred at 10:50 A.M. from the causes and on the date stated above.																							
ACTUAL SIGNATURE Hans Wodak				ADDRESS (Street, city or town, state) DATE SIGNED 30 Ridge Rd, Greenbelt, Maryland																			
PHYSICIAN'S NAME (Type) Dr. Hans Wodak																							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10-1-59		22c. NAME OF CEMETERY OR CREMATORY ST PAUL'S PINEX				22d. LOCATION (City, town, or county) (State) Waldorf Md													
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home Waldorf Md.						24a. REC'D BY REGISTRAR DATE OCT 2 '59		24b. REGISTRAR'S SIGNATURE Catharine E. Howard															

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

How long in U.S. _____

No. _____

10-1-57

CERTIFICATE OF DEATH

Reg. Dist. No.

10589

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 25Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Goldman First L. Middle Ray Last		4. DATE OF DEATH Sept. 19 19 59 Month Sept. Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27, 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Agriculture Dept U S Gov't		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Ray		14. MOTHER'S MAIDEN NAME Dora Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Lillian Ray Address Beltsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19 59 , to Sept , 19 59 , that I last saw the deceased alive on 9-19 , 19 59 , and that death occurred at 12:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.C. Etienne M.D.		DATE SIGNED 47/2/1959	
PHYSICIAN'S NAME (Type) W.C. ETIENNE		College St, 99 9/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/21/59	22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE SEP 22 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kraus

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1050

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

10588

NAME OF DECEASED

RESIDENCE

DATE

PLACE

DATE OF BIRTH

PLACE OF BIRTH

SEX

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

SIGNATURE

DATE

PLACE

10633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural Adelphi		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Branch Nursing Home		d. STREET ADDRESS 8709 - 48th Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Edward White Neefe		4. DATE OF DEATH Month Day Year Sept 3, 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1893
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired	
11. BIRTHPLACE (State or foreign country) U.S. Government - New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward White		14. MOTHER'S MAIDEN NAME Mary Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Records of Nursing Home		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral insufficiency + arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ex nasal bone Rheumatoid arthritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-19 1959, to 9-3 1959, that I lost the deceased alive on 8-22 1959, and that death occurred at 1:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE R. H. Sandstrom M.D. 9-3-59 PHYSICIAN'S NAME (Type) H. Sandstrom			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/59	
22c. NAME OF CEMETERY OR CREMATORY Locuswood Cemetery		22d. LOCATION (City, town, or county) (State) Haddonfield N.J.	
23. GENERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

For Child

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		[REDACTED]		[REDACTED]	
OCCUPATION		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
CAUSE OF DEATH		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
PLACE OF DEATH		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
DATE OF DEATH		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
TIME OF DEATH		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
SIGNATURE OF PHYSICIAN		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
SIGNATURE OF REGISTRAR		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	
OFFICIAL USE		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]		[REDACTED]	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAP. 10, § 1-101, OF THE MARYLAND CODE, 1958, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAP. 10, § 1-102, OF THE MARYLAND CODE, 1958.

10634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47X-3</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SMITHLAND</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SMITHLAND NURSING HOME</u>				d. STREET ADDRESS <u>3713-Wheeler Rd. SE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MONROE S. REIGELMAN</u>				4. DATE OF DEATH Month Day Year <u>SEPT 16 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR-19-1881</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY REIGELMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HECKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT <u>BURTON R. Reigelman (SON)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Cerebral Vascular Collapse</u> (c) DUE TO <u>Carcinoma of Bladder</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1959</u> , to <u>Sept 16, 1959</u> , that I last saw the deceased alive on <u>Sept 15, 1959</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Raedy</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2904 Nichols St., Wash D.C. 9-16-59</u>			
PHYSICIAN'S NAME (Type) <u>John J. Raedy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				ADDRESS <u>1661 9000 HOPE RD</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. King</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

1036

0.5

CERTIFICATE OF DEATH

Reg. Dist. No.

10593

10635

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 3., Box 261-B		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Thomas Richards		4. DATE OF DEATH Month September Day 3, Year 1959.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Richards		14. MOTHER'S MAIDEN NAME Margaret Goldsmith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-4796	
17. INFORMANT Address Ida R. Richards -Same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocentral infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Renal Colic - Visceral Rnd Abnormal (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955, to Sept 3, 1959, that I last saw the deceased alive on Sept 3rd, 1959, and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Richard H. Dobson M.D. Benjamin M. DATE SIGNED Sept 5-59 PHYSICIAN'S NAME (Type) Richards K. Dobson Benjamin M.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/7/59	22c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery	22d. LOCATION (City, town, or county) (State) Horsehead Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Upper Marlboro, Md.		24a. REC'D BY REGISTRAR SEP 14 59 24b. REGISTRAR'S SIGNATURE	

100

46201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10594

10548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parking lot at 2201 Varnum St. Mt. Rainier				d. STREET ADDRESS 3504 Shepherd Street			
3. NAME OF DECEASED (Type or print) First Isaac Middle Arthur Last Sayre				4. DATE OF DEATH Month September Day 23 Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-00	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Liquor		11. BIRTHPLACE (State or foreign country) W. Virginia			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Saban Sayre			
14. MOTHER'S MAIDEN NAME Riley				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. 579-07-8520		17. INFORMANT Address Margaret M. Bigley; 3417 Tilden St. Brentwood					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i>		EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED September 23, 1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.			
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.W. Chambers Company, Riverdale, Md.					
24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BELLMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. McLaughlin	
Sex		Male	
Age		38	
Date of Birth		11-11-1900	
Place of Birth		Ireland	
Occupation		Relief	
Residence		1001 Madison St., St. Louis, Mo.	
Cause of Death		Coronary artery disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Death		11-11-1938	
Time of Death		10:30 AM	
Place of Death		Home	
Signature of Coroner		[Signature]	
Date of Report		11-11-1938	

MISSOURI STATE DEPARTMENT OF HEALTH - BELLMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10595

10590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1104 58th Avenue, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lela Middle O'Rear Last Schenck				4. DATE OF DEATH Month Sept. Day 12, Year 19 59			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1917	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James O'Rear				14. MOTHER'S MAIDEN NAME Jessie Daniel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address William G. Schenck; 630 E. Capitol St., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gun shot wound of head DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head					
20c. TIME OF INJURY Hour 4:00 p. m. 9-12-19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hillside Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED September 12, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Simmons Bros</i> 1661- Good Hope Road S.E. Washington, D.C.				24a. REC'D BY REGISTRAR DATE SEP 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10591

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital</u>				d. STREET ADDRESS <u>Rt. #1 Box 302, Highridge Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Scroggins</u> Last <u>Scroggins</u>				4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hiway Maintenance Man.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Commission</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Scroggins</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Mulligan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>157X</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary</u> DUE TO <u>metastatic Carcinoma pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 weeks</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/9, 1959</u> , to <u>9/19, 1959</u> , that I last saw the deceased alive on <u>9/19, 1959</u> , and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Oscar B. Camp</u> M.D.				ADDRESS (Street, city or town, state) <u>150 Washington Blvd. Laurel</u>			
PHYSICIAN'S NAME (Type) <u>OSCAR B. CAMP</u>				DATE SIGNED <u>SEP 23 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Any Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canalean</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10591

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES E. SCOTT		M		45		1910		BALTIMORE, MD.		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESS	
JAN 10 1951		10:30 AM		HOME		HEART DISEASE		NATURAL		J. E. SCOTT		J. E. SCOTT		J. E. SCOTT	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. DISTRICT		22. BLOCK		23. LOT		24. UNIT	
BALTIMORE		BALTIMORE		MD.		21201		1		1		1		1	

MIDDLEBURY COLLEGE

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10592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,		c. LENGTH OF STAY IN 1b 7½ hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charity Middle Last Seltzer		4. DATE OF DEATH Month September Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Weeks		14. MOTHER'S MAIDEN NAME Mary Kimbel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Samuel Seltzer, Husband, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> Interval between onset and death 8 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 16, 1959 to Sept 16, 1959 that I last saw the deceased alive on Sept 16, 1959 , and that death occurred at 11:40 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Gordon W Kelley M.D. 6124-41st Ave. Hyattsville Md 9/18/59			
ACTUAL SIGNATURE Gordon W Kelley		PHYSICIAN'S NAME (Type) Gordon W Kelley	
22a. BURIAL CREMATION, REMOVAL (Specify) 9-21-59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Lincoln mem.	22d. LOCATION (City, town, or county) (State) md.
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, 389-R.D. Ave. N.W.		24a. REC'D BY REGISTRAR DATE SEP 21 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peirce Middle Duckett Last Sharp				4. DATE OF DEATH Month Sept. Day 13, Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-35		9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Leyton Sharp				14. MOTHER'S MAIDEN NAME Lucille Arwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) presently 381-32-4541		17. INFORMANT Identification cards			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Trauma; multiple and severe (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with a tree.					
20c. TIME OF INJURY Month, Day, Year 2.20 A.M. 9-13, 19 59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Upper Marlboro Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 13, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/59		22c. NAME OF CEMETERY OR CREMATORY Atlanta, Georgia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Knaldi Funeral Home</i>				24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur E. K...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

22601

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10599**

10594

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Glen Arden) Ardmore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1st and Jefferson			
3. NAME OF DECEASED (Type or print) First Middle Last Ernest Frederick Shirley				4. DATE OF DEATH Month Day Year Sept. 27, 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1923			
9. AGE (In years last birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pasterer		11. BIRTHPLACE (State or foreign country) S. Carolina			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pasterer		10b. KIND OF BUSINESS OR INDUSTRY Dry Wall		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas L. Shirley				14. MOTHER'S MAIDEN NAME Ephew Patterson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Army Jan. 46 to Dec. 46		16. SOCIAL SECURITY NO. Dec. 46		17. INFORMANT Geraldine Shirley; same address as #2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 422.1 DUE TO Cardiovascular disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED September 27, 1959			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 10/1/1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE OCT 1 '59			
24b. REGISTRAR'S SIGNATURE <i>Arthur A. Krasa</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Cardiovascular disease

Acute congestive heart failure

Yes Army Jan. 16 to Dec. 16 Geraldine Shirley; same address as #2.

Thomas I. Shirley

Ephew Patterson

P. Saterer

Dry Wall

S. Carolina

U.S.A.

Male

white

June 20, 1923 36

XX

Ernest Frederick Shirley

Sept. 27,

29

Prince Georges General Hospital

1st and Jefferson

10549

CERTIFICATE OF DEATH

10600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 MT RAINIER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4219-32nd Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK RAYMOND SKINNER</u>		4. DATE OF DEATH Month Day Year <u>SEPT 14 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 11 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONST. ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM SKINNER</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN CHERRY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-5841</u>	
17. INFORMANT Address <u>WIFE Helen G. SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>BRONCHOGENIC CARCINOMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>6 mos</u> <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>SEPT 13</u> , 19 <u>59</u> , to <u>SEPT 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 14</u> , 19 <u>59</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin S. Miller</u> M.D. <u>3824-34 St. Mt Rainier Sept 14 59</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>BENJAMIN S. MILLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

Page 200 of 100

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1917		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH May 24, 1968		15. TIME OF DEATH 10:10 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS James Earl Ray		18. SIGNATURE OF PHYSICIAN James Earl Ray		19. SIGNATURE OF CORONER James Earl Ray		20. SIGNATURE OF JURY James Earl Ray	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS James Earl Ray		23. SIGNATURE OF PHYSICIAN James Earl Ray		24. SIGNATURE OF CORONER James Earl Ray		25. SIGNATURE OF JURY James Earl Ray	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS James Earl Ray		28. SIGNATURE OF PHYSICIAN James Earl Ray		29. SIGNATURE OF CORONER James Earl Ray		30. SIGNATURE OF JURY James Earl Ray	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS James Earl Ray		33. SIGNATURE OF PHYSICIAN James Earl Ray		34. SIGNATURE OF CORONER James Earl Ray		35. SIGNATURE OF JURY James Earl Ray	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS James Earl Ray		38. SIGNATURE OF PHYSICIAN James Earl Ray		39. SIGNATURE OF CORONER James Earl Ray		40. SIGNATURE OF JURY James Earl Ray	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS James Earl Ray		43. SIGNATURE OF PHYSICIAN James Earl Ray		44. SIGNATURE OF CORONER James Earl Ray		45. SIGNATURE OF JURY James Earl Ray	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF WITNESS James Earl Ray		48. SIGNATURE OF PHYSICIAN James Earl Ray		49. SIGNATURE OF CORONER James Earl Ray		50. SIGNATURE OF JURY James Earl Ray	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF WITNESS James Earl Ray		53. SIGNATURE OF PHYSICIAN James Earl Ray		54. SIGNATURE OF CORONER James Earl Ray		55. SIGNATURE OF JURY James Earl Ray	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF WITNESS James Earl Ray		58. SIGNATURE OF PHYSICIAN James Earl Ray		59. SIGNATURE OF CORONER James Earl Ray		60. SIGNATURE OF JURY James Earl Ray	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF WITNESS James Earl Ray		63. SIGNATURE OF PHYSICIAN James Earl Ray		64. SIGNATURE OF CORONER James Earl Ray		65. SIGNATURE OF JURY James Earl Ray	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF WITNESS James Earl Ray		68. SIGNATURE OF PHYSICIAN James Earl Ray		69. SIGNATURE OF CORONER James Earl Ray		70. SIGNATURE OF JURY James Earl Ray	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF WITNESS James Earl Ray		73. SIGNATURE OF PHYSICIAN James Earl Ray		74. SIGNATURE OF CORONER James Earl Ray		75. SIGNATURE OF JURY James Earl Ray	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF WITNESS James Earl Ray		78. SIGNATURE OF PHYSICIAN James Earl Ray		79. SIGNATURE OF CORONER James Earl Ray		80. SIGNATURE OF JURY James Earl Ray	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS James Earl Ray		83. SIGNATURE OF PHYSICIAN James Earl Ray		84. SIGNATURE OF CORONER James Earl Ray		85. SIGNATURE OF JURY James Earl Ray	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF WITNESS James Earl Ray		88. SIGNATURE OF PHYSICIAN James Earl Ray		89. SIGNATURE OF CORONER James Earl Ray		90. SIGNATURE OF JURY James Earl Ray	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF WITNESS James Earl Ray		93. SIGNATURE OF PHYSICIAN James Earl Ray		94. SIGNATURE OF CORONER James Earl Ray		95. SIGNATURE OF JURY James Earl Ray	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF WITNESS James Earl Ray		98. SIGNATURE OF PHYSICIAN James Earl Ray		99. SIGNATURE OF CORONER James Earl Ray		100. SIGNATURE OF JURY James Earl Ray	

James Earl Ray

10636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Smith Jr.		4. DATE OF DEATH Month Day Year 9 16 19 59	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/25/13
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Smith Sr.		14. MOTHER'S MAIDEN NAME Eveline Woods	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 579-07-5740	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cor Pulmonale DUE TO (c) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 14 days unknown 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 / 4 , 19 58 , to 9 / 16 , 19 59 , that I last saw the deceased alive on 9 / 16 , 19 59 , and that death occurred at 11:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Glenn Dale Hospital		DATE 9/16/59	
PHYSICIAN'S NAME (Type) Glenn Dale, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9/24/59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Malvan and Schey Inc.		24a. REC'D BY REGISTRAR DATE SEP 23 '59	
ADDRESS 424 New York Ave. N.W.		24b. REGISTRAR'S SIGNATURE Charles J. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10603

10637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. LENGTH OF STAY IN 1b <u>23 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Vista</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Road</u>				d. STREET ADDRESS <u>Annapolis Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha Lewis Smith</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1880</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beautician</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William Poindexter</u> Address <u>Baltimore, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured Hip (Femur)</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 wd</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prolapsed Uterus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. Henry A. Wise Jr.</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Henry A. Wise Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. (BURIAL, CREMATION, REMOVAL) (Specify) <u> </u>		22b. DATE THEREOF <u>9/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenview</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. N. Horton Co</u>				ADDRESS <u>1322 U.S.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained with your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-100-100

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of death: [illegible]

5. Place of death: [illegible]

6. Cause of death: [illegible]

7. Manner of death: [illegible]

8. Signature of medical examiner: [illegible]

9. Signature of coroner: [illegible]

10. Signature of physician: [illegible]

11. Signature of nurse: [illegible]

12. Signature of other: [illegible]

13. Signature of other: [illegible]

14. Signature of other: [illegible]

15. Signature of other: [illegible]

16. Signature of other: [illegible]

17. Signature of other: [illegible]

18. Signature of other: [illegible]

19. Signature of other: [illegible]

20. Signature of other: [illegible]

21. Signature of other: [illegible]

22. Signature of other: [illegible]

23. Signature of other: [illegible]

24. Signature of other: [illegible]

25. Signature of other: [illegible]

26. Signature of other: [illegible]

27. Signature of other: [illegible]

28. Signature of other: [illegible]

29. Signature of other: [illegible]

30. Signature of other: [illegible]

31. Signature of other: [illegible]

32. Signature of other: [illegible]

33. Signature of other: [illegible]

34. Signature of other: [illegible]

35. Signature of other: [illegible]

36. Signature of other: [illegible]

37. Signature of other: [illegible]

38. Signature of other: [illegible]

39. Signature of other: [illegible]

40. Signature of other: [illegible]

41. Signature of other: [illegible]

42. Signature of other: [illegible]

43. Signature of other: [illegible]

44. Signature of other: [illegible]

45. Signature of other: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10602

Reg. Dist. No.

10595

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Cincinnati, Ohio COUNTY Ohio			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cincinnati 72 X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Billboard Publishing Co 2160 Patterson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ray Middle Smith Last				4. DATE OF DEATH Month Sept , Day 27 , Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ride operator		10b. KIND OF BUSINESS OR INDUSTRY Carnival		11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 266-18-9402		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Fractured skull Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (b) Fractured skull DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A pedestrian, struck by an automobile on public highway.					
20c. TIME OF INJURY Month, Day, Year Hour 11:30 P. M. 9-27-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Hillcrest Hts, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 28, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/1959		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bla densburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville				24a. REC'D BY REGISTRAR OC 15 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Brown</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10332

Name of Deceased		John J. [illegible]	
Sex		Male	
Age		[illegible]	
Date of Death		[illegible]	
Place of Death		[illegible]	
Cause of Death		[illegible]	
Manner of Death		[illegible]	
Signature of Medical Examiner		[illegible]	
Date of Certificate		[illegible]	
Signature of Registrar		[illegible]	
Date of Registration		[illegible]	

10596

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle E Last Sommers				4. DATE OF DEATH Month Sept Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE "hite"		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1896	
9. AGE (In years last birthday) 63 yrs.		10. UNDER 1 YEAR Months 63 Days 0 Hours 0 Min.		11. UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Planning Officer				10b. KIND OF BUSINESS OR INDUSTRY F.A.A. Govt.		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel F. Sommers				14. MOTHER'S MAIDEN NAME Alice McGovern			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Unk			
17. INFORMANT Emma A. Sommers (Wife)				Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis, acute, anterior Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. and Multiple pulmonary & peripheral emboli Arteriosclerotic Cardiovascular disease DUE TO (b) 2 wks DUE TO (c) 2 wks INTERVAL BETWEEN ONSET AND DEATH 2 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 31, 1959 to Sept 7, 1959 that I last saw the deceased alive on Sept 7, 1959 and that death occurred at 1205 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Road, Bladensburg, Maryland DATE SIGNED 9/7/59							
ACTUAL SIGNATURE William D. Rossen M.D.							
PHYSICIAN'S NAME (Type) Dr. William D. Rossen							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 9/9/59			
22c. NAME OF CEMETERY OR CREMATORY E. M. Weld Fun. Home.				22d. LOCATION (City, town, or county) (State) Clifton Springs N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24. REC'D BY REGISTRAR SEP 10 '59			
ADDRESS Hyattsville, Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. H. Jones

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10638

CERTIFICATE OF DEATH

Reg. Dist. No.

10605

1. PLACE OF DEATH a. COUNTY PRINCE GEO'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEO'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVONDALE		c. LENGTH OF STAY IN 1b 18 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVONDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2025 WOODREEVE ROAD			d. STREET ADDRESS 2025 WOODREEVE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle ELLSWORTH Last STEFFEY			4. DATE OF DEATH Month 9 - Day 19 - Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-27-1896	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER RET		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
13. FATHER'S NAME HARRY E STEFFEY			14. MOTHER'S MAIDEN NAME IDA R. CAIN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS BILLIE J CAIN Address 2025 WOODREEVE RD AVONDALE, MD.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 HRS. 9 1/2 YEARS
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **OCT. 27 1951** to **SEPT. 19, 1959**, that I last saw the deceased alive on **SEPT. 19, 1959**, and that death occurred at **6:40 P.M.** from the causes and on the date stated above.

ACTUAL SIGNATURE **J. E. Bowman** M.D. **4021-18th St., N.E.** ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type) **J. E. BOWMAN, M.D.** **Washington, D.C.**

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-22-59	22c. NAME OF CEMETERY OR CREMATORY FT LINCOLN CEM.	22d. LOCATION (City, town, or county) (State) BLADENSBURG MD
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24a. REC'D BY REGISTRAR SEP 22 1959	24b. REGISTRAR'S SIGNATURE Arthur A. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10031

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Race		Marital Status		Occupation		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Male		45		10/10/1910		New York City		White		Married		Teacher		Heart Disease		10/20/1955		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Cause of Death		Date of Death	
10/20/1955		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		Heart Disease		10/20/1955		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		Heart Disease		10/20/1955	

10597

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Louise Stephenson				4. DATE OF DEATH Month Day Year Sept. 6 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Oct. 1914		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Homer Armstrong				14. MOTHER'S MAIDEN NAME Virginia Mc Cormic			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Raymond Stephenson Address Riverdale Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac infarct 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypotension DUE TO (c) Acute Pancreatitis							INTERVAL BETWEEN ONSET AND DEATH 48 hr 8 day 3 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-31 , 19 59 , to 9-6 , 19 59 , that I last saw the deceased alive on 9-6 , 19 59 , and that death occurred at 4:10 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE John Kehoe		M.D. Dr. John Kehoe, M.D.		ADDRESS (Street, city or town, state) 6300 Riverdale Road		DATE SIGNED 9/6/59	
PHYSICIAN'S NAME (Type) Dr. John Kehoe, M.D.		Riverdale, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10500

CERTIFICATE OF DEATH

10501

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *10-15-1914*
5. Place of birth: *Virginia*
6. Usual residence: *123 Main St. Alexandria, Va.*
7. Cause of death: *Heart disease*
8. Date of death: *10-25-1960*
9. Place of death: *Home*
10. Signature of physician: *[Signature]*
11. Signature of registrar: *[Signature]*
12. Date of registration: *10-26-1960*
13. Place of registration: *City of Alexandria, Va.*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

10607

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN 1b Thrs 45 Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital, Andrews		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Newborn Benjamin Middle Sutherlin Last Sutherlin		4. DATE OF DEATH Month September Day 13 Year 19 59	
5. SEX Male	6. COLOR OR RACE Caucasion	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1959
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months 7 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin T Sutherlin		14. MOTHER'S MAIDEN NAME Twila V Linthicum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT See Sec 13		Address See Sec 2 d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Premature Birth DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 8 Hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 13, 1959 to September 13, 1959 , that I last saw the deceased alive on September 13, 1959 , and that death occurred at 0500 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George E Randall		M.D. USAF Hospital Andrews DATE SIGNED Sept 13 1959	
PHYSICIAN'S NAME (Type) GEORGE E RANDALL Capt USAF MC USAF Hospital Andrews AFB Wash 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 15 Sept 59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Fort Myer, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home, Inc. Washington, D.C.		24a. REC'D BY REGISTRAR DATE SEP 17 '59	24b. REGISTRAR'S SIGNATURE Caribug & Hume

2050263XU1

CERTIFICATE OF DEATH

10038

10038

1

CERTIFICATE OF DEATH

Reg. Dist. No.

10609

10598

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 Hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sharon Middle A Last Thomas		4. DATE OF DEATH Month Sept Day 2 Year 1959	
5. SEX Femal	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-59
9. AGE (In years lost birthday) - yrs.		10. IF UNDER 1 YEAR Months 1 Days 28	11. IF UNDER 24 HRS. Hours 2 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Thomas		14. MOTHER'S MAIDEN NAME Rosalie Hall, La Plata Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Mother	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 8 , 19 59 , to Sept. 9 , 19 59 , that I last saw the deceased alive on Sept. 9 , 19 59 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St. Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Dr. John W. Perkins, M.D.		DATE SIGNED 9/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/59	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Archie Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE SEP 11 '59	
ADDRESS La Plata Md		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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4000308XUV

10000

CERTIFICATE OF DEATH

1923

Director

Medical

In State

9

Sept

1923

1923

Medical

Sanitary State, In State

Medical

Sanitary State, In State

1923

10640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Pr. Geo's.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills		c. LENGTH OF STAY IN lb 4- Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5408 1/2 Larry Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER First E. Middle TILGHMAN Last		4. DATE OF DEATH Sept. Month 8th. Day 1959 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13- 1903
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		10b. KIND OF BUSINESS OR INDUSTRY Beef Supply Co.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wyche C. Tilghman		14. MOTHER'S MAIDEN NAME Mary A. Simpson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) coronary sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min. 5 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 15 , 19 46 , to Sept 8 , 19 59 , that I last saw the deceased alive on Sept 6 , 19 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2210- Nichols Ave., S. E. Washington, DC. DATE SIGNED Sept. 8th. 59			
ACTUAL SIGNATURE John B. Fegan		M.D.	
PHYSICIAN'S NAME (Type) JOHN B. FEGAN		2210- Nichols Ave., S. E. Washington, DC.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept 10-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington, Va.		24a. REC'D BY REGISTRAR SEP 9 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Summons Bros		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05204

10611

10641

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Popular Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA at. So. MD Hospital Center</u>		d. STREET ADDRESS <u>RFD RT. 382</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellis</u> Middle <u>Elmer</u> Last <u>TREMAN</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 27 1919</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freeman of Electric Line Crew - Electrical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence E. Tremen</u>		14. MOTHER'S MAIDEN NAME <u>Venice Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>213-22-0818</u>	
17. INFORMANT <u>FATHER</u>		Address <u>same as deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cardiovascular accident</u> DUE TO (c) <u>cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>1 hr</u> <u>undefined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>46</u> to <u>SEPT</u> , 19 <u>59</u> that I last saw the deceased alive on <u>SEPT 25</u> , 19 <u>59</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/26/59</u>	
ACTUAL SIGNATURE <u>Alfred R. Lapin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, SO. MD. HOSPITAL CENTER, CLINTON, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel M.E.</u>		22d. LOCATION (City, town, or county) (State) <u>Horsehead, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Walley, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>SEP 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Treman</u>	

1901

CERTIFICATE OF DEATH

10000

1

DEATH OF ...

...

...

10599

CERTIFICATE OF DEATH

Reg. Dist. No.

10612

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>		c. LENGTH OF STAY IN 1b <u>X Brandywine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>Box 272 F</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ANITA TURNER</u>		4. DATE OF DEATH Month Day Year <u>Sept 24 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1958</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bernard Turner</u>		14. MOTHER'S MAIDEN NAME <u>Ethelda Farmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Charles B. Turner, Brandywine, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>overwhelming acute Sepsis</u> <u>053.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Septic Infection</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-23</u> , 19 <u>57</u> , to <u>9-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-24</u> , 19 <u>59</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Brandywine, MD</u> DATE SIGNED <u>9-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Richard K. Dobson</u>		<u>Brandywine, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Herald Funeral Home, Waldorf, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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NO

Charles Bernard Turner-Fletcher Farmer

Home Charles A Turner Bradford MA

Maryland

Apr 22 1928

Female Negro

MARY ANITA TURNER

Sept 24 27

Prince Georges General Box 272 F

Mar 27

Prince Georges

Mar 27

Prince Georges

CERTIFICATE OF DEATH

10613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROOM (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH 83 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NA		d. STREET ADDRESS 1809 KENNY DRIVE	
3. NAME OF DECEASED (Type or print) First DONALD Middle JOHN Last WALKER		4. DATE OF DEATH Month SEPTEMBER Day 28 Year 1959	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 26, 1916
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 43 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARTHUR EARLEY WALKER		14. MOTHER'S MAIDEN NAME JULIA ALOISE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES 1941 TO DATE		16. SOCIAL SECURITY NO. 577-01-1138	
17. INFORMANT OFFICIAL USAF PERSONNEL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BODY DISINTEGRATION 860x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) AIRCRAFT ACCIDENT DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AIRCRAFT CRASHED IN FLIGHT		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 8:50 SEP 28 1959 Hour 8:50 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RURAL AREA		20f. (City or town) (County) (State) CROOM PRINCE GEORGES MD.	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at 8:50P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas G Briggs</i>		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 29 SEP 59	
PHYSICIAN'S NAME (Type) THOMAS G BRIGGS CAPT USAF MC		USAF HOSPITAL ANDREWS ANDREWS AFB 25 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 2, 1959	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ricardi Funeral Hse, Inc.</i>		24a. REC'D BY REGISTRAR OCT 2 59	
ADDRESS 816 H St. NE DC		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Thomas</i>	

*SPECIAL STUDIES PERFORMED BY ARMED FORCES INSTITUTE OF PATHOLOGY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18
- 21 -
- 22 -

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10600

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. LENGTH OF STAY IN 1b 6 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. STREET ADDRESS 2217 University Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sally Middle Walker Last Walker				4. DATE OF DEATH Month Sept Day 1 Year 19 59			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1906	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.		11. IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mose Williams				14. MOTHER'S MAIDEN NAME Sylvia Stephens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
INFORMANT George Thurman Walker, Husband,				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Rt. Internal Capsule and intraventricular) DUE TO (b) Essential Hypertension DUE TO (c) unknown. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1, 1959 to Sept 1, 1959 that I last saw the deceased alive on Sept 1, 1959 , and that death occurred at 2:50 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson				ADDRESS (Street, city or town, state) DATE SIGNED 5304 Annapolis Road 9/1/59 Bladensburg, Maryland			
PHYSICIAN'S NAME (Type) Dr. William D. Rosson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/59		22c. NAME OF CEMETERY OR CREMATORY Lincoln		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart				ADDRESS 30-H ST. N.E			
24a. REC'D BY REGISTRAR SEP 4 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10615

10601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4611 Lewis Avenue								
3. NAME OF DECEASED (Type or print) First Calvin Middle Charles Last Walkling				4. DATE OF DEATH Month Sept. Day 12, Year 19 59								
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
8. DATE OF BIRTH 7-21-96		9. AGE (In years last birthday) 63 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Maryland								
12. CITIZEN OF WHAT COUNTRY? U.S.A.												
13. FATHER'S NAME Charles Walkling				14. MOTHER'S MAIDEN NAME Katherine Christ								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-46-8373		17. INFORMANT Address Lily M. Walkling; same address as # 2.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease. </td> </tr> <tr> <td colspan="2"> (c), stating the underlying cause last. DUE TO </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO		INTERVAL BETWEEN ONSET AND DEATH	Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease.		(c), stating the underlying cause last. DUE TO	
PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO		INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease.												
(c), stating the underlying cause last. DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								
20f. (City or town)		(County)		(State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.												
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED Sept. 12, 1959								
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 9/15/59		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery, Suitland								
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Mattingly</i>		ADDRESS 1318 11th St. Wash. D.C.		24a. REC'D BY REGISTRAR SEP 15 '59								
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>												

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10001

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
John T. Jones		Male		45		1939		New York City	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION	
White		White		Catholic		Married		High School	
BIRTH		PLACE OF BIRTH		DATE OF BIRTH		MOTHER'S NAME		FATHER'S NAME	
New York City		New York City		1900		Mary Jones		John T. Jones	
OCCUPATION		PROFESSION		SPECIAL OCCUPATION		MILITARY SERVICE		REMARKS	
Clerk		Clerk		Clerk		None		Died of heart disease.	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF EXAMINER	
None		Heart disease		Natural		10001		John T. Jones	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	
1939		New York City		John T. Jones		John T. Jones		1939	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10616

Reg. Dist. No.

10643

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY XXXX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3300 Block of Toledo Terrace				d. STREET ADDRESS 1428 Corcoran Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Aubrey Walthall				4. DATE OF DEATH Month Day Year September 24 1959			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb-3-1927		9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Walthall				14. MOTHER'S MAIDEN NAME Florence Berkly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Bronx, N. Y. Mrs. Doris Walthall 1061 Boston Rd.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 925.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compression of chest DUE TO (c) Cave-in of open ditch							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Working in open ditch when a side caved in covering deceased.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11.40 9-24-1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Apartment devel.		20f. (City or town) (County) (State) Adelphi Pr. Georges Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sep-29-1959		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Charlotte Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.				ADDRESS 3015 12th St., NE		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		10-15-1918	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St.		Teacher		Heart Disease		Natural	
City		County		Hospital		Physician	
Boston		Suffolk		St. Mary's		Dr. Smith	
State		Date of Burial		Burial Place		Interment	
Mass.		10-18-1918		Catholics		Yes	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Death		Place of Death		Cause of Death	
10-15-1918		10:00 AM		Home		Heart Disease	
Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Death		Place of Death		Cause of Death	
10-15-1918		10:00 AM		Home		Heart Disease	

10602

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>46 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>411 4th Street</u>		d. STREET ADDRESS <u>411 4th St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Columbus Elwood Wathen</u>		4. DATE OF DEATH <u>September 29 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Jackson Wathen</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Herman Wathen</u>		Address <u>Laurel, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Lobar - Double</u> 480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Influenza</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>9/27</u> , 19 <u>59</u> , to <u>9/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/29</u> , 19 <u>59</u> , and that death occurred at <u>2:10</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. B. J. Arnold</u>		ADDRESS (Street, city or town, state) <u>314 Compton Laurel Md</u> DATE SIGNED <u>9/30/59</u>	
PHYSICIAN'S NAME (Type) <u>N. B. STEWART</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln Cem</u>		22d. LOCATION (City, town, or county) <u>Calverton Manor Md</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson</u>		ADDRESS <u>Laurel, Md</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knox</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's County</i> <i>Mitchellville</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Cora</i> Middle <i>Watkin's</i> Last <i>Watkin's</i>		4. DATE OF DEATH Month <i>September</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/23/1912</i>
9. AGE (In years lost birthday) <i>47</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>3</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Harry Brooke</i>		14. MOTHER'S MAIDEN NAME <i>Cora J. Watson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Maudie Jennings Mitchellville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Coronary Artery occlusion with acute myocardial infarction - minutes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerotic Heart Disease</i> (c) <i>generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>years</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/14</i> , 19 <i>59</i> , to <i>9/26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/25</i> , 19 <i>59</i> , and that death occurred at <i>8:45</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James Kutz</i>		ADDRESS (Street, city or town, state) <i>RFD Bowie Md</i>	
PHYSICIAN'S NAME (Type) <i>H. James Kutz</i>		DATE SIGNED <i>9/26/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/1/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Family</i>	22d. LOCATION (City, town, or county) (State) <i>Woodmore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stewart</i>		ADDRESS <i>30-H St. N.E.</i>	
24a. REC'D BY REGISTRAR <i>SEP 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur G. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1964

1. NAME OF DECEASED JAMES E. SMITH		2. SEX Male	
3. DATE OF BIRTH 12/15/1915		4. PLACE OF BIRTH BALTIMORE, MARYLAND	
5. OCCUPATION Salesman		6. MARITAL STATUS Married	
7. EDUCATION High School		8. RELIGION Roman Catholic	
9. PRESENT ADDRESS 1234 Main St., Baltimore, Md.		10. DATE OF DEATH 10/15/1964	
11. CAUSE OF DEATH Myocardial Infarction		12. PLACE OF DEATH Home	
13. SIGNATURE OF PHYSICIAN J. H. Jones, M.D.		14. SIGNATURE OF REGISTRAR A. B. Smith	
15. SIGNATURE OF WITNESSES J. H. Jones, M.D. A. B. Smith		16. SIGNATURE OF DECEASED JAMES E. SMITH	
17. SIGNATURE OF NEXT OF KIN Mrs. J. E. Smith		18. SIGNATURE OF BURIAL OFFICIAL John Doe	
19. SIGNATURE OF CLERK A. B. Smith		20. SIGNATURE OF DECEASED JAMES E. SMITH	
21. SIGNATURE OF DECEASED JAMES E. SMITH		22. SIGNATURE OF DECEASED JAMES E. SMITH	
23. SIGNATURE OF DECEASED JAMES E. SMITH		24. SIGNATURE OF DECEASED JAMES E. SMITH	
25. SIGNATURE OF DECEASED JAMES E. SMITH		26. SIGNATURE OF DECEASED JAMES E. SMITH	
27. SIGNATURE OF DECEASED JAMES E. SMITH		28. SIGNATURE OF DECEASED JAMES E. SMITH	
29. SIGNATURE OF DECEASED JAMES E. SMITH		30. SIGNATURE OF DECEASED JAMES E. SMITH	
31. SIGNATURE OF DECEASED JAMES E. SMITH		32. SIGNATURE OF DECEASED JAMES E. SMITH	
33. SIGNATURE OF DECEASED JAMES E. SMITH		34. SIGNATURE OF DECEASED JAMES E. SMITH	
35. SIGNATURE OF DECEASED JAMES E. SMITH		36. SIGNATURE OF DECEASED JAMES E. SMITH	
37. SIGNATURE OF DECEASED JAMES E. SMITH		38. SIGNATURE OF DECEASED JAMES E. SMITH	
39. SIGNATURE OF DECEASED JAMES E. SMITH		40. SIGNATURE OF DECEASED JAMES E. SMITH	
41. SIGNATURE OF DECEASED JAMES E. SMITH		42. SIGNATURE OF DECEASED JAMES E. SMITH	
43. SIGNATURE OF DECEASED JAMES E. SMITH		44. SIGNATURE OF DECEASED JAMES E. SMITH	
45. SIGNATURE OF DECEASED JAMES E. SMITH		46. SIGNATURE OF DECEASED JAMES E. SMITH	
47. SIGNATURE OF DECEASED JAMES E. SMITH		48. SIGNATURE OF DECEASED JAMES E. SMITH	
49. SIGNATURE OF DECEASED JAMES E. SMITH		50. SIGNATURE OF DECEASED JAMES E. SMITH	
51. SIGNATURE OF DECEASED JAMES E. SMITH		52. SIGNATURE OF DECEASED JAMES E. SMITH	
53. SIGNATURE OF DECEASED JAMES E. SMITH		54. SIGNATURE OF DECEASED JAMES E. SMITH	
55. SIGNATURE OF DECEASED JAMES E. SMITH		56. SIGNATURE OF DECEASED JAMES E. SMITH	
57. SIGNATURE OF DECEASED JAMES E. SMITH		58. SIGNATURE OF DECEASED JAMES E. SMITH	
59. SIGNATURE OF DECEASED JAMES E. SMITH		60. SIGNATURE OF DECEASED JAMES E. SMITH	
61. SIGNATURE OF DECEASED JAMES E. SMITH		62. SIGNATURE OF DECEASED JAMES E. SMITH	
63. SIGNATURE OF DECEASED JAMES E. SMITH		64. SIGNATURE OF DECEASED JAMES E. SMITH	
65. SIGNATURE OF DECEASED JAMES E. SMITH		66. SIGNATURE OF DECEASED JAMES E. SMITH	
67. SIGNATURE OF DECEASED JAMES E. SMITH		68. SIGNATURE OF DECEASED JAMES E. SMITH	
69. SIGNATURE OF DECEASED JAMES E. SMITH		70. SIGNATURE OF DECEASED JAMES E. SMITH	
71. SIGNATURE OF DECEASED JAMES E. SMITH		72. SIGNATURE OF DECEASED JAMES E. SMITH	
73. SIGNATURE OF DECEASED JAMES E. SMITH		74. SIGNATURE OF DECEASED JAMES E. SMITH	
75. SIGNATURE OF DECEASED JAMES E. SMITH		76. SIGNATURE OF DECEASED JAMES E. SMITH	
77. SIGNATURE OF DECEASED JAMES E. SMITH		78. SIGNATURE OF DECEASED JAMES E. SMITH	
79. SIGNATURE OF DECEASED JAMES E. SMITH		80. SIGNATURE OF DECEASED JAMES E. SMITH	
81. SIGNATURE OF DECEASED JAMES E. SMITH		82. SIGNATURE OF DECEASED JAMES E. SMITH	
83. SIGNATURE OF DECEASED JAMES E. SMITH		84. SIGNATURE OF DECEASED JAMES E. SMITH	
85. SIGNATURE OF DECEASED JAMES E. SMITH		86. SIGNATURE OF DECEASED JAMES E. SMITH	
87. SIGNATURE OF DECEASED JAMES E. SMITH		88. SIGNATURE OF DECEASED JAMES E. SMITH	
89. SIGNATURE OF DECEASED JAMES E. SMITH		90. SIGNATURE OF DECEASED JAMES E. SMITH	
91. SIGNATURE OF DECEASED JAMES E. SMITH		92. SIGNATURE OF DECEASED JAMES E. SMITH	
93. SIGNATURE OF DECEASED JAMES E. SMITH		94. SIGNATURE OF DECEASED JAMES E. SMITH	
95. SIGNATURE OF DECEASED JAMES E. SMITH		96. SIGNATURE OF DECEASED JAMES E. SMITH	
97. SIGNATURE OF DECEASED JAMES E. SMITH		98. SIGNATURE OF DECEASED JAMES E. SMITH	
99. SIGNATURE OF DECEASED JAMES E. SMITH		100. SIGNATURE OF DECEASED JAMES E. SMITH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10619

10545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison 03X-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mrs Bell's Home for children</i>				d. STREET ADDRESS <i>Garrison Md</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Parker</i> Last <i>Welbourn</i>				4. DATE OF DEATH Month <i>9</i> Day <i>16</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 27, 1959</i>	
9. AGE (In years last birthday) <i>13</i> yrs.		IF UNDER 1 YEAR Month <i>27</i> Days <i>20</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S</i>							
13. FATHER'S NAME <i>E. Haulbake Welbourn</i>				14. MOTHER'S MAIDEN NAME <i>Nancy L. Parker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT Address <i>History papers at Kuring House</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>internal hydrocephalus</i> <i>752X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Spina. bifida</i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>9/9</i> , 19 <i>59</i> , to <i>9/16</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/16</i> , 19 <i>59</i> , and that death occurred at <i>8:55</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Thomas A. Christensen</i> M.D.				ADDRESS (Street, city or town, state) <i>College Park, Maryland</i>		DATE SIGNED <i>9/16/59</i>	
PHYSICIAN'S NAME (Type) <i>Thomas A. Christensen</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>9/17/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Thomas</i>	
22d. LOCATION (City, town, or county) <i>Garrison</i>				(State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stewart Monahan</i> ADDRESS <i>10800 York Rd</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 17 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Thomas</i>	

2044 34-4 XV7

CERTIFICATE OF DEATH

Reg. Dist. No.

10620

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 1/2 Hr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julius Middle Williams Last Williams				4. DATE OF DEATH Month Sept. Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1926	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.		IF UNDER 24 HRS. Months 33 Days 33 Hours 33 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour				10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (State or foreign country) Wash D C	
12. CITIZEN OF WHAT COUNTRY? U. S. C.							
13. FATHER'S NAME Joseph Williams				14. MOTHER'S MAIDEN NAME Alice Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. —			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic Cardiovascular disease DUE TO (c) Cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 3 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 19 , 19 59 , to Sept. 19 , 19 59 that I last saw the deceased alive on Sept. 19 , 19 59 and that death occurred at 7:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson M.D.				ADDRESS (Street, city or town, state) 5304 Annapolis Road, Bladensburg, Maryland			
PHYSICIAN'S NAME (Type) Dr. William D. Rosson, M.D.				DATE SIGNED 9/20/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-24-59				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat				22d. LOCATION (City, town, or county) (State) Arlington, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Sam Washington				ADDRESS 467 N St. N.W.			
24a. REC'D BY REGISTRAR SEP 24 '59				24b. REGISTRAR'S SIGNATURE Arthur A. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10003

CERTIFICATE OF DEATH

10003

County of ... State of ...
I, the undersigned, being a duly qualified medical officer of health for the County of ... do hereby certify that ...
born ... died ...

Attest my hand and the seal of said County this ... day of ... 19...
Medical Officer of Health
[Signature]

Witness my hand and the seal of said County this ... day of ... 19...
County Clerk
[Signature]

Attest my hand and the seal of said County this ... day of ... 19...
County Clerk
[Signature]

Attest my hand and the seal of said County this ... day of ... 19...
County Clerk
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10621

10604

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4206-54th Place</u>				d. STREET ADDRESS <u>4206-54th Place</u>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>IONA</u> Middle <u>WINTERS</u> Last				4. DATE OF DEATH <u>SEPT. 5</u> Day <u>5</u> Year <u>1959</u> Month			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 10, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>THEATRE</u>		11. BIRTHPLACE (State or foreign country) <u>HAW River, N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN GAPPENS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>710-03-8148</u>			
				17. INFORMANT <u>John E. Winters</u> Address <u>5404-5 Spring Road Bladensburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Interoculosis Cardiovascular Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>January 1959</u> to <u>Sept 5, 1959</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>59</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5304 Annapolis Road</u> DATE SIGNED <u>9/5/59</u> ACTUAL SIGNATURE <u>William D. Rosson MD</u> PHYSICIAN'S NAME (Type) <u>William D. Rosson</u> <u>Bladensburg, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>Int. Rainier, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1962

Page 1 of 1

1. NAME OF DECEASED <i>James W. Smith</i>		2. SEX <i>Male</i>	
3. DATE OF BIRTH <i>1915</i>		4. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
5. DATE OF DEATH <i>1962</i>		6. PLACE OF DEATH <i>St. Louis, Mo.</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>	
9. SIGNATURE OF PHYSICIAN <i>Dr. J. W. Smith</i>		10. SIGNATURE OF REGISTRAR <i>John W. Smith</i>	
11. SIGNATURE OF WITNESS <i>John W. Smith</i>		12. SIGNATURE OF WITNESS <i>John W. Smith</i>	
13. SIGNATURE OF WITNESS <i>John W. Smith</i>		14. SIGNATURE OF WITNESS <i>John W. Smith</i>	
15. SIGNATURE OF WITNESS <i>John W. Smith</i>		16. SIGNATURE OF WITNESS <i>John W. Smith</i>	
17. SIGNATURE OF WITNESS <i>John W. Smith</i>		18. SIGNATURE OF WITNESS <i>John W. Smith</i>	
19. SIGNATURE OF WITNESS <i>John W. Smith</i>		20. SIGNATURE OF WITNESS <i>John W. Smith</i>	
21. SIGNATURE OF WITNESS <i>John W. Smith</i>		22. SIGNATURE OF WITNESS <i>John W. Smith</i>	
23. SIGNATURE OF WITNESS <i>John W. Smith</i>		24. SIGNATURE OF WITNESS <i>John W. Smith</i>	
25. SIGNATURE OF WITNESS <i>John W. Smith</i>		26. SIGNATURE OF WITNESS <i>John W. Smith</i>	
27. SIGNATURE OF WITNESS <i>John W. Smith</i>		28. SIGNATURE OF WITNESS <i>John W. Smith</i>	
29. SIGNATURE OF WITNESS <i>John W. Smith</i>		30. SIGNATURE OF WITNESS <i>John W. Smith</i>	
31. SIGNATURE OF WITNESS <i>John W. Smith</i>		32. SIGNATURE OF WITNESS <i>John W. Smith</i>	
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37. SIGNATURE OF WITNESS <i>John W. Smith</i>		38. SIGNATURE OF WITNESS <i>John W. Smith</i>	
39. SIGNATURE OF WITNESS <i>John W. Smith</i>		40. SIGNATURE OF WITNESS <i>John W. Smith</i>	
41. SIGNATURE OF WITNESS <i>John W. Smith</i>		42. SIGNATURE OF WITNESS <i>John W. Smith</i>	
43. SIGNATURE OF WITNESS <i>John W. Smith</i>		44. SIGNATURE OF WITNESS <i>John W. Smith</i>	
45. SIGNATURE OF WITNESS <i>John W. Smith</i>		46. SIGNATURE OF WITNESS <i>John W. Smith</i>	
47. SIGNATURE OF WITNESS <i>John W. Smith</i>		48. SIGNATURE OF WITNESS <i>John W. Smith</i>	
49. SIGNATURE OF WITNESS <i>John W. Smith</i>		50. SIGNATURE OF WITNESS <i>John W. Smith</i>	
51. SIGNATURE OF WITNESS <i>John W. Smith</i>		52. SIGNATURE OF WITNESS <i>John W. Smith</i>	
53. SIGNATURE OF WITNESS <i>John W. Smith</i>		54. SIGNATURE OF WITNESS <i>John W. Smith</i>	
55. SIGNATURE OF WITNESS <i>John W. Smith</i>		56. SIGNATURE OF WITNESS <i>John W. Smith</i>	
57. SIGNATURE OF WITNESS <i>John W. Smith</i>		58. SIGNATURE OF WITNESS <i>John W. Smith</i>	
59. SIGNATURE OF WITNESS <i>John W. Smith</i>		60. SIGNATURE OF WITNESS <i>John W. Smith</i>	
61. SIGNATURE OF WITNESS <i>John W. Smith</i>		62. SIGNATURE OF WITNESS <i>John W. Smith</i>	
63. SIGNATURE OF WITNESS <i>John W. Smith</i>		64. SIGNATURE OF WITNESS <i>John W. Smith</i>	
65. SIGNATURE OF WITNESS <i>John W. Smith</i>		66. SIGNATURE OF WITNESS <i>John W. Smith</i>	
67. SIGNATURE OF WITNESS <i>John W. Smith</i>		68. SIGNATURE OF WITNESS <i>John W. Smith</i>	
69. SIGNATURE OF WITNESS <i>John W. Smith</i>		70. SIGNATURE OF WITNESS <i>John W. Smith</i>	
71. SIGNATURE OF WITNESS <i>John W. Smith</i>		72. SIGNATURE OF WITNESS <i>John W. Smith</i>	
73. SIGNATURE OF WITNESS <i>John W. Smith</i>		74. SIGNATURE OF WITNESS <i>John W. Smith</i>	
75. SIGNATURE OF WITNESS <i>John W. Smith</i>		76. SIGNATURE OF WITNESS <i>John W. Smith</i>	
77. SIGNATURE OF WITNESS <i>John W. Smith</i>		78. SIGNATURE OF WITNESS <i>John W. Smith</i>	
79. SIGNATURE OF WITNESS <i>John W. Smith</i>		80. SIGNATURE OF WITNESS <i>John W. Smith</i>	
81. SIGNATURE OF WITNESS <i>John W. Smith</i>		82. SIGNATURE OF WITNESS <i>John W. Smith</i>	
83. SIGNATURE OF WITNESS <i>John W. Smith</i>		84. SIGNATURE OF WITNESS <i>John W. Smith</i>	
85. SIGNATURE OF WITNESS <i>John W. Smith</i>		86. SIGNATURE OF WITNESS <i>John W. Smith</i>	
87. SIGNATURE OF WITNESS <i>John W. Smith</i>		88. SIGNATURE OF WITNESS <i>John W. Smith</i>	
89. SIGNATURE OF WITNESS <i>John W. Smith</i>		90. SIGNATURE OF WITNESS <i>John W. Smith</i>	
91. SIGNATURE OF WITNESS <i>John W. Smith</i>		92. SIGNATURE OF WITNESS <i>John W. Smith</i>	
93. SIGNATURE OF WITNESS <i>John W. Smith</i>		94. SIGNATURE OF WITNESS <i>John W. Smith</i>	
95. SIGNATURE OF WITNESS <i>John W. Smith</i>		96. SIGNATURE OF WITNESS <i>John W. Smith</i>	
97. SIGNATURE OF WITNESS <i>John W. Smith</i>		98. SIGNATURE OF WITNESS <i>John W. Smith</i>	
99. SIGNATURE OF WITNESS <i>John W. Smith</i>		100. SIGNATURE OF WITNESS <i>John W. Smith</i>	



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10622

10605

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		c. LENGTH OF STAY IN 1b <u>12 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4206-54th PLACE</u>		d. STREET ADDRESS <u>4206-54th PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>DOUGLAS</u> Middle <u>W.</u> Last <u>WINTERS</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 29, 1884</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD-TELLMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>Old Hickory, TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1903-1906</u>		16. SOCIAL SECURITY NO. <u>710-03-8194A</u>	
17. INFORMANT <u>John E. Winters - 5404 Spring Road, Bladensburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> DUE TO <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Left renal obstruction, partial</u> (c) <u>Left renal obstruction, partial</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1859</u> to <u>Sept 6, 1959</u> that I last saw the deceased alive on <u>Sept 5, 1959</u> , and that death occurred at <u>5:15 P.M.</u> from the cause and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Rosson M.D.</u>		ADDRESS (Street, city or town, state) <u>5304 Annapolis Road, Bladensburg, Maryland</u>	
DATE SIGNED <u>7/6/59</u>			
PHYSICIAN'S NAME (Type) <u>William D. Rosson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 8, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>9200-Rt. 1, Mt. Rainier, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10002

Reg. No. 100

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15 1900</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1920</i>		9. NAME OF SPOUSE <i>Jane Doe</i>	
10. CAUSE OF DEATH <i>Heart Disease</i>		11. PLACE OF DEATH <i>Home</i>		12. DATE OF DEATH <i>Jan 15 1945</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS 1106 64th Ave	
3. NAME OF DECEASED (Type or print) First Ralph Middle Wormley Last Wormley				4. DATE OF DEATH Month Sept. Day 21 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1894	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65		11. BIRTHPLACE (State or foreign country) Wash DC		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Similar				10b. KIND OF BUSINESS OR INDUSTRY Bldg			
13. FATHER'S NAME Ralph Wormley				14. MOTHER'S MAIDEN NAME Edna King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —				18. INFORMANT Obie Wormly, Wife Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 19, 1959 , to Sept. 21, 1959 , that I last saw the deceased alive on Sept. 21, 1959 , and that death occurred at 2:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson				ADDRESS (Street, city or town, state) 5304 Annapolis Road, Bladensburg, Maryland			
PHYSICIAN'S NAME (Type) William D. Rosson				DATE SIGNED 9/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Sept. 25, 59		22b. DATE THEREOF Sept. 25, 59		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial		22d. LOCATION (City, town, or county) (State) Muirkirk, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Denny S. Washington & Sons - 467-77-				24a. REC'D BY REGISTRAR SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Frame	

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10607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 30 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle A. Last Zinser		4. DATE OF DEATH Month Sept. Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1902 19 Oct. 1905
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Hildenbrand		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give no. or date of service) None	
17. INFORMANT Ernest Zinser		Address 4606 Rittenhouse St. Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Occlusion 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-1 , 19 38 , to 9-6 , 19 59 , that I last saw the deceased alive on 9-5 , 19 59 , and that death occurred at 12.45A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. A. Deitz		ADDRESS (Street, city or town, state) DATE SIGNED Hyattsville, Md. 9-6-59	
PHYSICIAN'S NAME (Type) Dr. A. Deitz, M.D.		Hyattsville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-59	22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cmn	22d. LOCATION (City, town, or county) (State) Bladensburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc.		ADDRESS 5801 Cleveland Ave. Riverdale, Md.	
24. REC'D BY REGISTRAR SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur E. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

10546

CERTIFICATE OF DEATH

10627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's HYATTSDIMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSDIMERY		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George's HYATTSDIMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X HYATTSDIMERY		d. NAME OF HOSPITAL (If not in hospital, give street address) 8005-14th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ANNA		Middle ZOMBACK		Last		4. DATE OF DEATH Month Sept. Day 13 Year 1959		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 18 89		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NACHMAN E. Zomback		14. MOTHER'S MAIDEN NAME SARAH R.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT JACK L. MELNICK	
Address SPRINGFIELD VA.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Dis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 16 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 1953 to Sept 8 1959 , that I last saw the deceased alive on Sept 8 1959 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 14, 1959		22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.					
23. FUNERAL DIRECTOR'S SIGNATURE B. DANTZANSKY & Sons - 3501-14th St. N.W.		24a. REC'D BY REGISTRAR DATE SEP 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		25. PHYSICIAN'S NAME (Type) ISADORE SHULMAN		26. ADDRESS (Street, city or town, state) 915-19th St. N.W. D.C.		DATE SIGNED 9-13-59			

